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TITLE VI – Medicaid and SCHIP

Subtitle A- Medicaid

Chapter 1 – Payment for Prescription Drugs

Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions (Section 6001 of the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill)**.**

a. Modification of Federal Upper Payment Limit for Multiple Source Drugs; Definition of Multiple Source Drugs. --

Current Law

States set the amounts to pay pharmacies for outpatient prescription drugs provided to Medicaid enrollees. States pay those amount to pharmacies and then seek reimbursement of the federal share of those payments. Federal reimbursements to states for state spending for certain outpatient prescription drugs are subject to ceilings called federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs — those that have at least three therapeutically equivalent drug versions. The Centers for Medicare and Medicaid Services (CMS) calculates the FUL to be equal to 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale prices (AWP) for each group of drug equivalents. Brand name drugs are subject to an upper limit equal to the amount that pharmacists must pay to acquire the drug (the acquisition cost) as estimated by the states.

Pharmaceutical manufacturers whose drugs are available to Medicaid beneficiaries must provide state Medicaid programs with rebates. Rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain other products, the best price at which the manufacturers sell the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation. Sales at prices that are "nominal" in amount are excluded from the computation of best price. CMS defines nominal prices to be those that are below 10% of the AMP.

Senate Bill

The Senate bill would specify that FULs for multiple source drugs provided in pharmacies that are not critical access pharmacies would be calculated to be equal to 115% of the weighted AMP for those drugs. The FULs for multiple source drugs provided in critical access pharmacies would be calculated to be equal to the lesser of 140% of the AMP or the wholesale acquisition cost (WAC) for the drug. The bill would establish FULs for single source drugs. For those single source drugs provided in pharmacies that are not critical access pharmacies, the FUL would be calculated to be equal to 105% of the AMP. FULs for those single source drugs provided in critical access retail pharmacies would be calculated to be equal to the lesser of 108% of the AMP or the WAC for the drug.

Exceptions to the FUL would be for drugs sold during an initial sales period in which data on sales for the drug are not sufficiently available from the manufacturer to compute the AMP or the weighted AMP, and for drugs for which alternatives would not be as effective. For drugs sold during an initial sales period, the Senate bill would establish a transitional upper payment limit to apply only during such period. For a period not to exceed 2 calendar quarters, the upper limit for single source drugs would be calculated to be equal to the wholesale acquisition cost

(WAC) for the drug. The bill would define WAC - the definition would be identical to the current law Medicare definition. For first non-innovator multiple source drugs, the upper limit during the transition period would be equal to the AMP for the single source drug rated as therapeutically equivalent minus 10%. For subsequent non-innovator multiple source drugs, if the Secretary has sufficient data to determine AMP, the FUL during the transition period would be equal to the weighted AMP for the therapeutically equivalent and bioequivalent form of the drug. If the Secretary does not have sufficient data, the FUL would be the AMP for the single source drug that is therapeutically equivalent and bioequivalent minus 10%.

In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a non-innovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with the states' program, the upper payment limit for the innovator multiple source drug shall be equal to 105% of the AMP for such drug.

The Secretary would be required to update FULs on a quarterly basis, taking into account the most recent data collected for the purposes of determining such limits and the FDA's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations."

The Senate FUL provisions would become effective on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of enactment.

The Senate bill would establish interim FULs to apply during calendar year 2006, before the new FULs become effective. During the period January 1, 2006 through the effective date of the FUL provisions, the Secretary would apply the FUL as under current law and regulations except that instead of limiting federal matching to 150% of AWP, it would be limited to 125% of AWP. In the case of covered outpatient drugs that are marketed as of July 1, 2005 and are subject to FULs under current law, the Secretary would be required to use the AWPs, direct prices, and WACs as of that date to calculate the applicable FUL. New drugs first marketed between July 1, 2005 and January 1, 2007 would be subject to this interim FUL calculation.

House Bill

The House bill would specify that the FUL for the ingredient cost of a multiple source drug would be equal to 120% of the volume weighted average RAMP for that drug. The bill would establish upper limits for single source drugs as well. The FUL for the ingredient cost of a single source drug would be equal to the 106% of the RAMP for that drug. A drug product that is a single source drug and that becomes a multiple source drug would continue to be treated as a single source drug, with respect to the applicable FUL, until the Secretary determines that there is sufficient data to compile the volume weighted average RAMP.

The House bill would provide the Secretary with an option to develop an alternative methodology setting the FUL based on the most recently reported retail survey price instead of a percentage of RAMP or the volume weighted average RAMP. The House bill would allow the Secretary to use this methodology, in 2007, for a limited number of covered outpatient drugs, including both single source and multiple source drugs selected to be representative of the classes of drugs dispensed under Medicaid.

The House bill provides exceptions to the FULs for drugs sold during an initial sales period and for drugs dispensed by specialty pharmacies. For those drugs sold during an initial sales period for which data for computation of the RAMP may not be available, the House bill includes a provision similar to the Senate provision, except it would apply only to single source drugs sold during the initial sales period and the provision does not include any specification for

first innovator multiple source drugs. The bill includes a definition of WAC, to be used during the initial sales period, that is identical to the definition of WAC in the Senate bill. The House bill would also allow a state to elect not to apply the new FUL to covered outpatient drugs dispensed by specialty pharmacies, such as those that dispense only immunosuppressive drugs, as defined by the Secretary, or drugs administered by a physician in a physician's office.

The House bill would require the Secretary to update the FULs at least on a quarterly basis. Otherwise, the provision regarding FUL updates is identical to the Senate provision.

The effective date for the House FUL provisions would be on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the state legislature that begins after the date of enactment of this Act.

The House bill would provide the Secretary with the authority to delay the implementation of the new FUL limits for a period of not more than 1 year, if the Comptroller General finds that the estimated average payment amount to pharmacies for covered outpatient drugs under the new FULs are below the average prices paid by pharmacies for acquiring such drugs. If the Secretary delays the implementation of the FULs then the Secretary would be required to transmit to Congress, prior to the termination of the period of delay, a report containing specific recommendations for legislation to establish a more equitable payment system.

The House bill would clarify that the FULs would not affect maximum allowable cost limits as established by states and rebates would continue to be paid without regard to whether or not states' payments are subject to such a limit. In addition, it would prohibit administrative and judicial reviews of the Secretary's determinations of FULs, RAMPs, volume weighted average RAMPs including the:

- assignment of National Drug Codes to billing and payment classes;
- Secretary's disclosure to states of AMP, RAMP, volume weighted average RAMP, and retail survey prices;
- determinations by the Secretary of covered outpatient drugs dispensed by specialty pharmacies or administered in physicians' offices;
- contracting and calculations under these provisions; and
- methods of allocating rebates, chargebacks, or other price concessions if specified by the Secretary.

The House bill would require the Comptroller General of the U.S. to provide a report to Congress no later than nine months after the date of enactment on the appropriateness of payment levels to pharmacies for dispensing fees under the Medicaid program and on whether the estimated average payment amounts to pharmacies for covered outpatient drugs under the new FUL method are below the average prices paid by pharmacies for acquiring such drugs. The bill would also require the Inspector General of HHS to provide a report to Congress, no later than two years after the date of enactment, on the appropriateness of using RAMP and retail survey prices rather than the AMP or other price measures, as the basis for establishing a FUL for reimbursement of outpatient drugs under Medicaid.

Conference Agreement

The conference agreement applies FULs to multiple source drugs for which the FDA has rated 2 or more products to be therapeutically and pharmaceutically equivalent. For those drugs, the FUL would be equal to **250%** of the average manufacturer price computed without regard to prompt pay discounts for the lowest cost drug. Effective January 1, 2007.

The agreement modifies the definition of multiple source drug so that a drug qualifies as a multiple source drug if there is at least one other drug sold and marketed during the period that is rated as therapeutically equivalent and bioequivalent to it.

b. Disclosure of Price Information to States and the Public

Current Law

AMP and best price data are required to be reported by manufacturers to CMS no later than 30 days after the date of entering into a rebate agreement and then no later than 30 days after the last day of each rebate period. Those prices are required to be kept confidential except for the purpose of carrying out the requirements of Medicaid rebates, or to permit the Comptroller General and the Director of the Congressional Budget Office to review the information.

Senate Bill

The Senate bill would modify the confidentiality requirements to allow states access to reported price information and would require the Secretary to make available to states, beginning with the first quarter of FY2006, the most recently reported AMP and weighted AMPs. The Secretary would be required to devise and implement a means of electronic distribution for these prices to state Medicaid agencies.

House Bill

The House bill would modify the confidentiality requirements to allow states access to reported price information. In addition, the bill would require the Secretary to devise and implement a means for electronic distribution to state Medicaid agencies, of retail survey prices.

Conference Agreement

The conference agreement would increase the required reporting of AMP and best prices. AMP would be reported and calculated on a monthly basis.. In addition, the agreement allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and would require the Secretary to disclose such information through a website accessible to the public. In addition, the provision requires the Secretary to provide AMPs to States on a monthly basis and to update information posted to the website on at least a quarterly basis.

c. Definition of Average Manufacturer Price. --

Current Law

The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. CMS instructs manufacturers to exclude certain federal drug purchases as well as free goods from the computation of AMP. Sales at nominal prices are excluded from the best price computation. Manufacturers are required to report, for each rebate period, the AMP for all Medicaid covered outpatient drug products and the best price for single source and innovator multiple source drugs to CMS.

Senate Bill

The Senate bill would modify the definition of AMP and require the modified AMP to be used to calculate the FUL for single source drugs in addition to rebates, as under current law. The provision would specify that sales exempted from inclusion in the determination of best price, nominal price sales (except for those contingent on purchase requirements or agreements), and bona fide service fees would be exempted from the computation of the AMP. Computation

of AMP would include cash and volume discounts; nominal price sales contingent on a purchase agreement or requirement; free goods; chargebacks or rebates to a pharmacy (excluding mail order, nursing home pharmacies and pharmacy benefit managers), or any other direct or indirect discounts; and any other price concessions which may be based on recommendations of the Inspector General of HHS. Bona fide user fees would be defined as expenses for a service actually performed by an entity for a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.

The Senate bill would define the weighted AMP, to be used in calculating the FUL for multiple source drugs, with respect to the rebate period, as the volume-weighted average of manufacturers' reported prices for all drug products that are therapeutically equivalent and bioequivalent. It would be computed by summing, for all therapeutic equivalents and bioequivalent forms of the drug, the products of the AMP and the number of units sold. The sum of those amounts would be divided by the sum of all units sold for all NDCs assigned to such products. In cases in which there is a lag in the reporting of information on rebates and chargebacks so that adequate data are not available on a timely basis to update the weighted AMP for a multiple source drug, the manufacturer of such drug would apply a methodology based on a 12-month rolling average to estimate costs attributable to rebates and chargebacks for such drugs. For years after 2006, the Secretary would be required to establish a uniform methodology to estimate and apply such costs.

The Senate bill would modify the existing price reporting requirements so that manufacturers would be required to report the modified AMP and the weighted AMP to the Secretary of CMS as well as information and data on any sales made during the reporting period at a nominal price. The bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine AMP, prices, volume, and other data necessary to calculate the FUL and payment limits for covered drugs.

The Senate modifications to the definition of AMP would become effective as if enacted on July 1, 2005 except for the provisions related to the exclusion of nominal prices from AMP. Those provisions would become effective on the later of the expiration date of a contract in effect on the date of enactment or October 1, 2006 and would apply to sales made and rebate periods beginning on or after that date.

House Bill

The House bill would not change AMP. Instead it would establish a measure of price referred to as RAMP for the purpose of calculating the FUL for single source drugs. RAMP would be defined as the average price paid to a manufacturer for the drug in the U.S. in the quarter by wholesalers for drugs distributed to retail pharmacies, excluding service fees. For this purpose, retail pharmacies would be defined to exclude mail-order only pharmacies and pharmacies at nursing facilities and homes. Specified items to be excluded from RAMP are similar to those to be excluded from AMP in the Senate bill except that the House bill allows the Secretary to define nominal sales, and free goods contingent on purchase requirements would not be excluded from RAMP. In addition, service fees that represent fair market value for a bona-fide service provided by the entity would be excluded from RAMP. Items to be included in RAMP are also similar to those included in AMP in the Senate bill except that RAMP includes free goods contingent upon a purchase requirement; and does not provide for an exception for mail order, nursing home pharmacies and pharmacy benefit managers.

The volume weighted average RAMP would be defined, for all drug products in the same multiple source drug billing and payment code (or other methodology as specified by the Secretary), as the volume weighted average of the reported RAMPs. It would be computed by summing the products of the RAMPs for all product with an NDC code and multiplying by the total number of units of the drug product sold. Those amounts would be summed together and divided by the total number of units sold for all NDC codes assigned to such products.

The House bill would establish reporting requirements of drug manufacturers. Manufacturers would be required, beginning after July 1, 2006, to submit the RAMP, the total number of units required to compute the volume weighted average RAMP, the WAC for drugs sold during an initial sales period, and information on nominal price sales. The reporting would be by National Drug Code (NDC). In addition, the bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine RAMPs and other data necessary to calculate the FULs and payment limits and would modify the confidentiality provisions allowing states access to reported price information.

Conference Agreement

The conference agreement amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers from those amounts. In addition, the agreement modifies the price reporting requirements so that manufacturers would be required to submit, not later than 30 days after the last day of each rebate period, the customary prompt pay discounts extended to wholesalers in addition to the AMP and best price reporting required under current law.

The conference agreement requires the Inspector General of the Department of Health and Human Services (HHS) to, no later than June 1, 2006, review the requirements for, and the manner in which AMP is determined and to submit to the Secretary and Congress any recommendations for changes as determined to be appropriate.

The agreement also requires the Secretary of HHS to promulgate a regulation clarifying the requirements for and the manner in which AMPs are to be determined, taking into consideration the recommendations of the Inspector General.

d. Exclusion of Sales at a Nominal Price from Determination of Best Price --

Current Law

In addition to the AMP, pharmaceutical manufacturers are required to report to the Secretary of HHS the "best price" at which the manufacturer sells each of its drug products to certain purchasers for the purpose of calculating the rebate amounts. Prices that are nominal in amount are excluded from best price reporting. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price.

Senate Bill

The Senate bill would exclude, for the purposes of computing the AMP, sales by a manufacturer of covered outpatient drugs that are single source, innovator multiple source drugs, or are authorized generics that are made available at nominal prices to the following listed entities: a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations would not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule. In addition, the bill would modify manufacturers' price reporting requirements to include, for calendar quarters beginning on or after January 1, 2006 information on sales made at a nominal price.

House Bill

The House bill would exclude, for the purpose of computing the RAMP, sales as the Secretary identifies, that are nominal in amount. In addition, the bill would modify manufacturers' price reporting requirements to include, for calendar quarters beginning on or after July 1, 2006 information on sales made at a nominal price.

Conference Agreement

The conference agreement modifies the manufacturer price reporting requirements so that for calendar quarters beginning on or after January 1, 2007, manufacturers would be required to report information on sales of Medicaid covered drugs that are made at a nominal price.

In addition, the agreement defines the sales are to be considered nominal for the purpose of reporting nominal price sales and for computing and reporting the best price. (The agreement does not amend the AMP vis-a-vis nominal prices.) Nominal sales are those made by a manufacturer of covered drugs at nominal prices to a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations do not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.

e. Retail Survey Prices; State Payment and Utilization Rates; and Performance Rankings. --

Current Law

No provision.

Senate Bill

No provision.

House Bill

The House bill would allow the Secretary to contract with a vendor to obtain retail survey prices for Medicaid covered outpatient drugs that represent a nationwide average of pharmacy sales costs for such drugs, net of all discounts and rebates. Such a contract would be awarded for a term of 2 years.

The Secretary would be required to competitively bid for an outside vendor with a demonstrated history in surveying and determining on a representative nationwide basis, retail prices for ingredient costs of prescription drugs; working with retail pharmacies, commercial payers, and states in obtaining and disseminating price information; and collecting and reporting price information on at least a monthly basis. The contract would include the terms and conditions specified by the Secretary and would include a requirement that the vendor monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug available nationwide; update the Secretary no less often than monthly on the retail survey prices for multiple source drugs and on the computed upper payment limit for those drugs; to independently confirm retail survey prices. Information on the retail survey prices obtained through this process, including information on single source drugs would be required to be provided to states on an ongoing and timely basis.

Conference Agreement

The conference agreement includes a provision similar to the House provision. The agreement allows the Secretary to contract for services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs. The conference agreement adds a provision allowing such a contract to include notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available. The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs. The contract shall be effective for a term of two years. If the Secretary were to be notified that such a product has become generally available, the Secretary would be required to make a determination within 7 days as to whether the drug meets the definition of a multiple source drug subject to the application of the FUL. The agreement allows the Secretary to waive those provisions the Secretary determines are appropriate to waive, of the Federal Acquisition Regulation, for the efficient implementation of the contract.

The agreement does not require the contractor to independently confirm retail survey prices, as in the House bill, and does not require the Secretary to provide for electronic distribution to states. On the other hand, the Secretary would be required to devise and implement a means for providing access to each state Medicaid agency of collected price information and to provide information on retail survey prices, including information on single source drugs, to states at least monthly.

The agreement requires an annual report from each state agency. States are required to provide to the Secretary, the payment rates for all covered drugs, dispensing fees and utilization of innovator multiple source drugs under the state Medicaid plan. The Secretary is required to compare, on an annual basis, for the 50 most widely prescribed drugs, the national retail sales price data for each state. In addition, the Secretary is required to submit full information regarding the annual rankings to Congress. The provision becomes effective on January 1, 2007.

(f) Miscellaneous Amendments. --

Current Law

States are required to have in place a program of prospective drug review wherein before each prescription is filled, the use of the prescription is screened for potential drug therapy problems. The requirement includes language clarifying that nothing in the provision is intended to require a pharmacist to provide this consultation when a beneficiary refuses such a consultation.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement clarifies that the requirement to provide prospective drug reviews is not intended to require verifications that consultations were offered or refused.

Effective on the date of enactment.

(g) Effective Date

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

Unless otherwise specified, the provisions in Section 6001 take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Collection and Submission of Utilization Data for Certain Physician Administered Drugs (Section 6002 of the Conference Agreement, Section 6004 of the Senate Bill, and Section 3102 of the House Bill)**.**

Current Law

Manufacturers are required to provide rebates to states for all outpatient prescription drugs with some exceptions. Outpatient prescription drugs provided through managed care organizations are explicitly exempted from the rebate requirement. In addition, outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. Certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, have often been excluded from the drug rebate program although there is no specific statutory exclusion. This is because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectible prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide States with the specific manufacturer information necessary to enable them to seek rebates. The NDC number is necessary for the state to bill manufacturers for rebates. CMS has requested that states identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates can be collected for these drugs (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003). CMS has concluded that because of this coding, many state Medicaid programs have not collected rebates on these drugs, resulting in millions of dollars in uncollected rebates.

Senate Bill

As a condition of receiving Medicaid payment, states would be required to submit, to the Secretary of HHS, utilization data and coding information for physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required. The reporting would include J-codes and National Drug Code numbers. The purpose of the reporting would be to allow the Secretary to secure rebates for such drugs.

Effective upon enactment.

House Bill

As a condition of receiving Medicaid payment, and in order to secure rebates for physician administered drugs states would be required to submit:

— No later than January 1, 2006, utilization data and coding information for single source drugs or biologicals that are physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required.

— No later than January 1, 2007, utilization data and coding information by NDC (unless the Secretary identifies an alternative coding system) for multiple source drugs.

— No later than January 1, 2008, utilization and coding information for those drugs on the list of 20 high volume physician administered drugs.

No later than January 1, 2007, the Secretary would be required to publish a list of the 20 physician administered multiple source drugs that have the highest volume of physician administered dispensing under Medicaid. The Secretary would be able to modify such list from year.

The Secretary would be permitted to delay the application of the reporting requirements in the case of a State to prevent hardship to Sates that require additional time to implement such a reporting system.

Conference Agreement

The agreement includes a provision similar to the House provision. For drugs administered on or after January 1, 2006, states are required to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. For drugs administered on or after January 1, 2008, states are required to provide for the collection and submission of utilization and coding information for each Medicaid multiple source drug that is physician administered. Submissions from states will be based on National Drug Codes unless the Secretary specified an alternative coding system. All other provisions are identical to the House bill.

Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug, and Cosmetic Act (Section 6003 of the Conference Agreement, Section 6003 of the Senate Bill, and Section 3103 of the House Bill).

Current Law

Prescription drug manufacturers participating in the Medicaid program are required to report, to the Secretary of HHS, the AMP for each pharmaceutical product offered under Medicaid and, for each brand name drug product, the best price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term ‘best price' is defined in the Medicaid statute but only with respect to single source and innovator multiple source drugs since the best price is part of the rebate computation for only those drugs. These reported prices are used to calculate rebates - which are generally calculated separately for brand name drug products and for generics.

Sometimes manufacturers produce both a brand name version of a prescription drug and also sell or license a second manufacturer (or a subsidiary) to produce some of the same product to be sold or re-labeled as a generic. These generics, called "authorized generics," are subject to a separate rebate calculation. Rebates for brand name products, take into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic.

Current law defines best price with respect only to a single source drug or innovator multiple source drug, as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, HMO, nonprofit entity, or governmental entity within the U.S. excluding prices charged to specified governmental purchasers. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation.

Senate Bill

The Senate bill would modify the existing drug price reporting requirements to include, for single source drugs, innovator multiple source drugs, authorized generic drugs, and any other drugs sold under a new drug application approved (under Section 505c of the Federal Food, Drug and Cosmetic Act, FFDCA) by FDA, both the average manufacturer's price and the manufacturer's best price for such drugs. An authorized generic drug would be defined as a listed drug that has been approved by the FDA under Section 505(c) of such Act and is marketed, sold or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging the listed drug for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.

The definition of best price would be modified so that, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug to be sold under an NDA, it is inclusive of the lowest price such drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity. The definition of AMP would be modified to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average price paid for such drugs. The provision would become effective on January 1, 2006.

House Bill

The provision would modify the existing drug price reporting requirements for pharmaceutical manufacturers. No later than 30 days after the last day of each rebate period, manufacturers would be required to report,

- for each covered outpatient drug, including those sold under a new drug application approved by the FDA, the average manufacturer's price for such drugs; and,

- for single source drugs, innovator multiple source drugs, and any other drug sold under a new drug application approved by the FDA, the manufacturers best price for such drugs during the applicable rebate period.

Not later than 30 days after the date of entering into a drug rebate agreement, manufacturers would be required to report on the average manufacturer price for each of the manufacturer's covered outpatient drugs, including those sold under a new drug application approved by the FDA.

The definition of best price would be changed to apply, not only to each single source drug and innovator multiple source drug, but also to drugs sold under a new drug application (NDA) approved by (under Section 505c of FFDCA) FDA. In addition, the definition would be modified so that the best price, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity except for those entities excluded under current law. The provision would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits a drug of the manufacturer

to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs. The provision would become effective on January 1, 2006.

Conference Agreement

The agreement includes a provision similar to the Senate provision. The provision is different from the Senate provision in that it does not refer to the affected drugs as "authorized generics". Instead, the agreement uses the phrase "any drug of the manufacturer sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act" to include authorized generics. The conference agreement does not include a definition of "authorized generics." In addition, the definition of best price would be modified so that it is inclusive, in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the FFDCA, of the lowest price for an authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the U.S. The effective date would be January 1, 2007.

Children's Hospital Participation in Drug Discount Program (Section 6004 of the Conference Agreement, no provision of the Senate Bill, and Section 3104 of the House Bill)**.**

Current Law

Section 340(B) of the Public Health Service Act allows certain health care providers, including community health centers and disproportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.

Senate Bill

No provision.

House Bill

The House bill would include a provision adding Children's Hospitals to the list of providers that may have access to 340(B) discounted prices. The provision would become effective for drugs purchased on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Dispensing Fees (No provision in the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill)**.**

Current Law

States are allowed to pay pharmacies reasonable dispensing fees.

Senate Bill

The Senate bill would require states to establish dispensing fees that are (a) greater for non-innovator multiple source drugs than those for innovator multiple source drugs that are therapeutically equivalent and bioequivalent; and (b) that take into account requirements established by the Secretary to include reasonable costs associated with a pharmacist's time checking an individual's coverage or performing quality assurance; measuring or mixing of a

drug; filing the container; providing the completed prescription; delivery; special packaging; physical overhead and salaries of pharmacists and other pharmacy workers; geographic factors that impact costs; patient counseling; and drugs requiring specialty pharmacy management services.

The Senate bill would require, no later than 15 months after the date of enactment, with quarterly updates thereafter, the Secretary to establish of list of covered outpatient drugs requiring specialty pharmacy care management services. The list would include only those drugs for which the Secretary determines that access to the drug would be seriously impaired without the provision of such care management services. Specialty pharmacy care management services would be defined as those services provided in connection with the dispensing of a covered drug that requires:

- significant caregiver contact, education about the disease state, prevention, treatment, drug indications, benefits, risks, complications, pharmacy counseling and explanation;
- patient compliance services including coordination of provider visits with drug delivery, compliance with dosing regimen, mailing or telephone call reminders, compiling compliance data, assistance providers with compliance programs;
- tracking services, referral processes, screening referrals, and tracking patient weight for dosage.

In addition, the Senate bill would require states to consider, in establishing dispensing fees, the costs associated with operating a critical access retail pharmacy.

House Bill

The House bill would require states to pay a dispensing fee for each covered outpatient drug. States would be allowed to vary dispensing fees to take into account the special circumstances of pharmacies serving rural and underserved areas and sole community pharmacies. Dispensing fees for drugs defined as multiple source drugs under the FUL policy would be required to be no less than $8 per prescription unit. The Secretary would be required to define what constitutes a prescription unit for this purpose.

Conference Agreement

No provision.

Increase in rebates for covered outpatient drugs (No provisions of the Conference Agreement, Sections 6001, 6002 and 6039D of the Senate Bill, and no provisions of the House Bill) **.**.

Current Law

Basic Medicaid rebates for single source and innovator multiple source drugs are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and best price for each drug. In addition, if the prices of single source or innovator multiple source drugs rise faster than inflation, additional rebates are due. Rebates for all other multiple source drugs is equal to 11% of the AMP.

Senate Bill

The Senate bill would modify the formulas for prescription drug rebates under the Medicaid program. Beginning on January 1, 2006, rebates for single source and innovator multiple source drugs would be equal to the greater of 18.1% of the AMP or the difference between the reported AMP and the best price for each drug. (Sections 6002(a)(3) and 6001(b)(2).)

Rebates for single source and innovator multiple source drugs equal to 17.8% of the AMP or the difference between the reported AMP and the best price for each drug. (Section 6039D.)

Rebates for all other drugs would be equal to 17%.Changes to the rebate formula would begin on January 1, 2006.

House Bill

No provision.

Conference Agreement

No provision.

Extension of rebates to Medicaid MCOs (No provisions of the Conference Agreement, Sections 6001 and 6038 of the Senate Bill, and no provisions of the House Bill)**.**

Current Law

Rebates are not required for drugs dispensed by Medicaid managed care organizations (MCO) when the drugs are paid as part of the MCO capitation rate, to drugs provided in hospitals, and sometimes in physicians', or dentists' offices.

Senate Bill

Section 6001(a)(5) of the Senate bill would establish rebates for drugs dispensed by Medicaid MCOs. States would have the option of collecting rebates directly from manufacturers or allowing the MCO to collect the rebates in exchange for a reduction in the prepaid payment made to the entity for Medicaid enrollees. The provision would become effective on the date of enactment and would apply to Medicaid rebate agreements entered into or renewed on or after that date.

Section 6038 would establish rebates for drugs dispensed by Medicaid MCOs except for those drugs purchased at discounted prices under the Public Health Service Act Sec. 340B drug discount program.

House Bill

No provision.

Conference Agreement

No provision.

Improving Patient Outcomes (No provision of the Conference Agreement, no provision of the Senate Bill, and Section 3105 of the House Bill)**.**

Current Law

States may establish a prior authorization program as long as the system provides a response for a request for approval within 24 hours, and as long as the program allows for a dispensing of at least a 72 hour supply of a covered drug in an emergency situation. Other restrictions may be imposed if they are necessary to discourage waste, fraud or abuse.

Senate Bill

No provision.

House Bill

The provision would limit the ability of states to place atypical antipsychotic or antidepressant single source drugs on prior authorization lists imposing other restrictions unless a drug use review board has determined that doing so is not likely to harm patients or increase overall medical costs. It also would require states to pay for a 30 day supply of such drugs in cases where a request for authorization is not responded to within 24 hours after the prescription is transmitted. The provision would be effective on January 1, 2007.

Conference Agreement

No provision.

Chapter 2 – Long-Term Care Under Medicaid

Subchapter A- Reform of Asset Transfer Rules **Lengthening Look-Back Period; Change in Beginning Date for Period of Ineligibility.**

Lengthening Look-back Period for all Disposals to 5 years (Section 6011(a) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(a) of the House Bill)**.**

Current Law

Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations. States may choose to apply this ineligibility period to other state plan long-term care services. (They also currently apply to home and community care for functionally disabled elderly individuals under section 1929 of the Act. This is an optional coverage group which operates only in Texas.) In general, states do not extend the penalty to Medicaid's acute care services.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to 5 years, or 60 months, for all income and assets disposed of by the individual after this Act's date of enactment. For income and assets disposed of prior to the

enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply. The House bill would become effective on the date of the enactment of this Act.

Conference Agreement

The conference agreement includes the House provision.

Change in Beginning Date for Period of Ineligibility (Section 6011(b) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(b) of the House Bill)**.**

Current Law

The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period. Some penalties imposed on applicants who made improper transfers within the look-back period and prior to the date of Medicaid application may expire before the date of Medicaid application. For example, an improper transfer of $100,000 made 2 years prior to Medicaid application could result in a 20-month penalty period ($100,000 divided by the private rate for a nursing home state in a state of $5,000). Since the individual applies to Medicaid two years, or 24 months, after having made the transfer, the penalty has already expired before the individual applies to Medicaid. However, if the transfer of $100,000 is made one year prior to Medicaid application, the penalty of 20 months would not have expired before the applicant needed Medicaid coverage, but rather would continue for eight months after Medicaid application.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(D) of the Social Security Act by changing the start date of the ineligibility period for all transfers made on or after the date of the enactment, to the first day of a month during or before which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and is receiving certain long-term care services, whichever is later and which does not occur during any period of ineligibility as a result of an asset transfer policy. For transfers made prior to this Act's enactment, current law applies.

Conference Agreement

The conference agreement includes the House provision but specifies that the start date begins on the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy.

Effective Date (Sections 6011(c) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(c) of the House Bill**).**

Current Law

Currently effective.

Senate Bill

No provision.

House Bill

The amendments made by this section would apply to transfers made on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Availability of Hardship Waivers (Sections 6011(d) and (e) of the Conference Agreement, Section 6011(f) of the Senate Bill, and Sections 3111(d) and (e) of the House Bill)**.**

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss: (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Senate Bill

The Senate bill would amend Section 1917(c) of the Social Security Act by adding a requirement that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care so that the individual's health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

House Bill

The House bill would amend section 1917(c)(2)(D) of the Social Security Act to specify the criteria by which an application for an undue hardship waiver would be approved. Approval would be subject to a finding that the application of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered, or that the individual would be deprived of food, clothing, shelter, or other necessities of life. States would also be required to provide for: (A) notice to recipients that an undue hardship exception

exists; (B) a timely process for determining whether an undue hardship waiver will be granted; and (C) a process under which an adverse determination can be appealed.

This provision would also amend section 1917(c)(2) of the Social Security Act to permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Conference Agreement

The conference agreement includes the House provision.

Disclosure and Treatment of Annuities and of Large Transactions (Section 6012 of the Conference Agreement, Section 6011(d) of the Senate Bill, and Section 3112 of the House Bill)**.**

Current Law

Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place. The State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound.

States and courts interpret this guidance differently. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. In a recent case in Ohio, a state court ruled that it was proper to look at the intent of asset transfers, even if the annuity was actuarially sound. (*Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. Appl., 12th, No. CA2003-09-093, Nov. 22, 2004).

Medicaid Estate Recovery. Current law requires states to recover the private assets (e.g., countable and non-countable assets) of the estates of deceased beneficiaries who have received certain long-term care services. Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21 and no surviving child who is blind or has a disability. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual and is limited to only certain assets that remain in the estate of the beneficiary upon his or her death. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state probate law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. Thus assets such as living trusts, life insurance

policies, certain annuities, which may pass to heirs outside of probate, would be subject to Medicaid recovery only if a state expanded its definition of "estate."

Senate Bill

The Senate bill would amend section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The Senate bill would amend section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

The Senate bill would amend Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

House Bill

The House bill would amend section 1917 of the Social Security Act by adding a new subsection that would require individuals, at the initial application or recertification for certain Medicaid long-term care services, to disclose to the state the following:

(A) A description of any interest the individual has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a noncountable assets, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset;

(
Applications or recertification forms shall include a statement that designates the state as the remainder beneficiary under such an annuity or similar financial instrument, subject to the following provisions:

(A) For institutionalized individuals who receive certain Medicaid-covered long-term care services, the state would become the remainder beneficiary in the first position of an annuity (in which he or she has an interest) for the total amount paid by Medicaid on behalf of the individual; The state becomes the remainder beneficiary in the second position when there is a spouse, minor, or disabled child as a named beneficiary.

(B) In the case of disclosure concerning an annuity, the state would notify the annuity's issuer of the state's right as a preferred remainder beneficiary in the annuity for Medicaid services furnished to the individual. This provision would not prevent the issuer from notifying persons with any other remainder of the state's interest in the remainder.

(C) The state may require an issuer to notify when there is a change in the amount of income or principal being withdrawn from the amount being withdrawn at the time of the most recent disclosure, as specified above. A state would take such information into account when determining the amount of the state's obligations for Medicaid or the individual's eligibility. Such a change in amount would be deemed as a transfer of an asset for less than fair market value unless the individual demonstrates, to the state's satisfaction, that the asset transfer was for fair market value.

The Secretary may provide guidance to states on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

The House bill would not prevent a state from denying Medicaid eligibility for an individual based on the income or resources derived from an annuity.

The House bill would apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment.

Conference Agreement

The conference agreement requires individuals, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form includes a statement naming the state as the remainder beneficiary. In the case of disclosure concerning an annuity, the state notifies the annuity's issuer of the state's right as a preferred remainder beneficiary for Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest.

States may require an issuer to notify the state when there is a change in the amount of income or principal withdrawn from the amount withdrawn at the point of Medicaid application or recertification. States take this information into account when determining the amount of the state's financial share of costs or in the individual's eligibility for Medicaid.

The Secretary may provide guidance to states on categories of transactions that may be treated as a transfer of asset for less than fair market value. States may deny eligibility for medical assistance for an individual based on the income or resources derived from an annuity.

The conference agreement amends section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

The conference agreement amends section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in subsection (b) and (q) of section 408 of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in subsections (a), (c), and (p) of section 408 of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by

actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The amendments apply to transactions, including the purchase of annuity, occurring on or after the date of this Act's enactment.

Application of Income-First Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse (Section 6013 of the Conference Agreement, no provision in the Senate Bill, and Section 3113 of the House Bill)**.**

Current Law

Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid (community spouse) with little or no income or assets when the other spouse is institutionalized or, at state option, receives Medicaid's home- and community-based services. Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage, to be available to pay for care for the spouse needing Medicaid coverage. These rules created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the other spouse could qualify for coverage. MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules.

Regarding income, current law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, section 1924(d) of the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance for each community spouse to try to ensure that the community spouse has sufficient income to meet his or her basic monthly needs. (The community spouse's minimum monthly maintenance needs allowance is set at a level that is higher than the official federal poverty level.) Once income is attributed to each of the spouses according to their ownership interest, the community spouse's monthly income is compared against the minimum monthly maintenance needs allowance. If the community spouse's monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse *may* choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e. the difference between the community spouse's monthly income and the state- specified minimum monthly maintenance needs allowance). This transfer allows more income to be available to the community spouse, while Medicaid pays a larger share of the institutionalized spouse's care costs. Within federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no greater than $2,377.50 per month, and no less than $1,561.25 per month in 2005.

Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource allowance (CSRA). Federal requirements specify that this amount may be no greater than $95,100 and no less than $19,020 in total countable assets in 2005. When determining eligibility, all assets of the couple are combined, counted, and split in half, regardless of ownership. If the community spouse's share of the assets is less than the state-specified maximum, then the Medicaid beneficiary *must* transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

States have some flexibility in the way they apply these rules at the time in which a person applies through the fair hearing process to raise his or her minimum maintenance needs allowance. At this point, a state may decide to allocate more income or resources from the institutionalized spouse to the community spouse. In doing so, states have employed two divergent methods. Under the method used by most states, known as the "income-first" method, the state requires that the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet or, if approved by the state, exceed the minimum monthly maintenance needs allowance; the remainder, if any, is applied to the institutionalized spouse's cost of care. Under this method, the assets of an institutionalized spouse (e.g. an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse unless the income transferred by the institutionalized spouse would not enable the community spouse's total monthly income to reach the state-approved monthly maintenance needs allowance. This method generally requires a couple to deplete a larger share of their assets than the resources-first method.

In contrast, under the other method, known as the "resources-first" method, the couple's resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income, including income generated by the CSRA, meets or, if approved by the state, exceeds the community spouse's minimum monthly maintenance needs allowance. Additional income from the institutionalized spouse that may be, but has not been, made available for the community spouse is used toward the cost of care for the institutionalized spouse. This method generally allows the community-spouse to retain a larger amount of assets than the income-first method.

On September 7, 2001, the Secretary issued a proposed rule (Federal Register Vol. 66, No. 174) that would have codified state practices. The proposed rule would have allowed states to choose between using either the income-first or resources-first method when determining whether the community spouse has sufficient income to meet the minimum monthly maintenance needs allowance. Under the proposed rule, states would not have been able to apply different rules to different individuals, on a case-by-case basis. The Secretary has not issued a final rule.

Senate Bill

No provision.

House Bill

The House bill would amend section 1924(d) of the Social Security Act to require that any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse's monthly income allowance be first made from income of the institutionalized spouse. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated.

The House bill would apply to transfers and allocations made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Conference Agreement

The conference agreement amends section 1924(d), and therein sections (c) and (e), of the Social Security Act to require that states consider that all income of the institutionalized spouse that could be made available to the community spouse, in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing, has been made before states allocate the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse. These amendments apply to transfers and allocations

made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity (Section 6014 of the Conference Agreement, no provision in the Senate Bill, and Section 3114 of the House Bill)**.**

Current Law

Within federal law, states set asset standards that applicants must meet to qualify for Medicaid coverage. Among other things, these standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which types of assets are counted and not counted. In general, countable assets cannot exceed $2,000 for an individual applicant. States generally follow SSI rules for computing both countable and non-countable assets.

Under Medicaid and SSI rules, the value of an item may be totally or partially excluded when calculating countable resources. For example, the entire value of a car, regardless of its worth, is excluded, but life insurance is counted to the extent that the cash surrender value exceeds $1,500 (if the total value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be counted for eligibility purposes).

Current Medicaid and SSI asset counting practices general exclude the entire value of an applicant's home. A home is defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. However, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $750,000. (The Secretary would establish a process to waive application of this provision for demonstrated cases of hardship.) This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest $1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Conference Agreement

The Conference agreement amends section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. A state may elect an amount that exceeds $500,000, but does not exceed $750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest $1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Section 6015 of the Conference Agreement, no provision in the Senate Bill, and Section 3115 of the House Bill)**.**

Current Law

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees and who often reside in such CCRCs throughout their older years. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. Many also offer home care, maid services and laundry. CCRCs were developed, in large part, in response to an interest among many elderly persons to age-in-place. CCRCs can be either for-profit or not-for-profit CCRCs. They are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do. Under current law, section 1919(c)(5)(A)(i)(II) of the Social Security Act prohibits a Medicaid-certified nursing facility from requiring that individuals provide them with oral or written assurance that they are not eligible for, or will not apply for, Medicaid or Medicare benefits.

Senate Bill

No provision.

House Bill

The House bill would amend section 1919(c)(5)(A)(i)(II) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) that are certified to accept Medicaid and/or Medicare payment to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community

spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid.

The House bill would also amend section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. Entrance fees that would be considered a resource available to the individual would meet the following criteria:

(A) the individual would have the ability to use the entrance fee, or the contract provides that the entrance fee could be used, to pay for care should other resources or income of the individual be insufficient to pay for care;

(B) the individual would be eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community

Conference Agreement

The conference agreement includes the House provision except that a CCRC or life care community cannot retain a portion of an entrance fee, otherwise made available to spend on care before applying for Medicaid, on account of a community spouse's resource allowance.

Additional Reforms of Medicaid Asset Transfer Rules.

Requirement to Impose Partial Months of Ineligibility (Section 6016(a) of the Conference Agreement, Section 6011(a) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Current law requires states to impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

The length of the delay is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a state with an average private stay in a nursing home of $4,100, an ineligibility period for an improper transfer of $53,000 could be 12.92 months (i.e. $53,000/$4,100=12.92). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states may round down the quotient to an ineligibility period of 12 months only.

Senate Bill

The Senate bill would amend Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Authority for States to Accumulate Multiple Transfers into One Penalty Period (Section 6016(b) of the Conference Agreement, Section 6011(b) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the same month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. When a number of assets are transferred during *different* months, then the rules vary based upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision but refers to the disposal of multiple fractional transfers of assets instead of multiple assets.

Inclusion of Transfer of Certain Notes and Loans Assets (Section 6016(c) of the Conference Agreement, Section 6011(c) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets.

Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an individual's primary place of residence, one automobile, household goods and personal effects,[1] property essential to income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items.

Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

House Bill

No provision.

[1] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

Conference Agreement

The conference agreement includes the Senate provision.

Inclusion of Transfers to Purchase Life Estates (Section 6016(d) of the Conference Agreement, Section 6011(e) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Current law does not specify whether life estates should be treated as countable or noncountable assets for purposes of applying the Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to add a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Effective Date (Section 6016(e) of the Conference Agreement, Section 6011(g) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

No provision.

Senate Bill

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter

beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature. This amendment applies to provision under section 6011 of the Senate bill.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision with respect to amendments made by section 6016.

Subchapter B- Expanded Access to Certain Benefits

Expansion of State Long-Term Care Partnership Program (Section 6021 of the Conference Agreement, and Section 6012 of the Senate Bill, and Section 3133 of the House Bill)**.**

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than $2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects. Under section 1902 of the Social Security Act, a state may request the Secretary's permission to amend its Medicaid state plans to allow certain applicants to retain greater amounts of countable assets than other applicants and still qualify for Medicaid. Specifically, states that obtain the Secretary's approval may disregard some or all of the assets of persons applying for Medicaid who have purchased long-term care insurance policies.

Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) allows only those states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, have implemented partnership programs.

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a *dollar-for-dollar* model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., $100,000 of nursing home or assisted living benefits paid enables that individual to retain up to $100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a *total asset protection* model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. LTC insurance products are largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following.

Model Regulations:

- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:

- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

HIPPA also includes requirements that tax-qualified policies comply with consumer protections regarding the delivery of policies, information on denials of claims, and disclosure. While many state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

National Clearinghouse for Long-Term Care. No provision in current law requires the establishment of a long-term care consumer clearinghouse.

In related activities, DHHS has funded some states to establish state-based consumer-friendly access to information about long-term care services. In FY2003 and FY2004, the Centers for Medicare and Medicaid (CMS) and AoA awarded approximately $19 million in grants to states for the purpose of assisting their efforts to create a single, coordinated system of information and access for all persons seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. In FY2005, $15 million was awarded. A total of 43 states have received grants for this purpose. Some of the common activities under this grants program include information and referral, outreach, counseling about public benefits and long-term care options, and case management. States' methods for implementing the grant may vary; some states have established an actual physical location, and other states have established a statewide clearinghouse through a toll-free number or a web-based information site.

In addition, CMS has made available to the public, via its website, a comparison of Medicare and Medicaid-certified nursing homes and home health agencies. The information provides detailed facility and agency information and characteristics, and contains several measures of quality (e.g., improvement in mobility). This website does not cover assisted living facilities, group homes and other residential facilities that are not nursing facilities; nor does it cover non-medical, non-certified, home and community-based long-term care services.

Senate Bill

The Senate bill would exempt an additional group of persons with certain long-term care insurance plans from Medicaid estate recovery. This group would include individuals who received Medicaid under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below. The provision would also require that existing LTC insurance partnership programs satisfy requirements B through G below for LTC insurance policies sold on or after 2 years after enactment.

The Senate bill would define LTC insurance policies as including, but not be limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another states' Qualified LTC Insurance Partnership" or a long-term care insurance policy, the same as the state treats benefits paid under such a policy under the state's plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed $250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest $100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

- Guaranteed renewal or noncancellability;
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;

- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Suitability;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Standard format outline of coverage; and
- Deliver shopper's guide.

Model Act:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

- *Reciprocity.* These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such LTC insurance partnerships;
- *Minimum reporting requirements.* These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;
- *Suitability.* These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

- *Incontestability.* Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies sold under a state partnership program should be modified based on NAIC guidance;
- *Nonforfeiture.* Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;
- *Independent certification for benefits assessment.* Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;
- *Rating requirements.* Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and
- *Dispute Resolution.* Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures and federal Medicare expenditures.

Effective Date. These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

House Bill

The House bill would amend section 1917(b)(1)(C)(ii) of the Social Security Act to allow additional groups of individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. The term "Qualified State LTC Insurance Partnership," would mean a Medicaid State plan amendment that provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. (In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged);

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary;

(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection;

(IV) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (promulgated after consultation with the states), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines appropriate to the administration of such partnerships;

(VI) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Secretary, as appropriate, would provide copies of the state reports to the state involved and would promote the education of consumers regarding qualified state long-term care insurance partnerships. In addition, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, the Secretary would develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary may develop, in consultation with the states and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships.

Effective Date. A state plan amendment that provides for a qualified state long-term care insurance partnership would be effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

Conference Agreement

The conference agreement amends section 1917(b)(1)(C)(ii) of the Social Security Act to: 1) require that existing partnership programs not allow consumer protection standards, as defined it a Medicaid state plan amendment, to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and 2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;

(III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000).

Model Regulations relating to:

- Guaranteed renewal or noncancellability (including some sections of the Model Act);
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Delivery of shopper's guide.

Model Act relating to:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act are treated as including any other provision of the Regulation or Act necessary to implement the provision. Long-term care insurance policies issued in a state shall be deemed as meeting the requirements of the model regulation or the Model Act if the state plan amendment provides that the State insurance commissioner for the state certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.

(V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the data format and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved;

(VII) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, state insurance commissioners, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies, the Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update or other modification of a model regulation or model act provision listed above or substantially related those listed above, the Secretary reviews these changes, determines whether incorporating such changes into the corresponding provision would improve qualified state long-term care insurance partnerships, and, if so, incorporate the changes into the provision.

States may require issuers of long-term care insurance policies sold in that state (regardless of whether the policy is issued under a qualified state long-term care insurance partnership) to report additional information or data to the state.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary develops no later than January 1, 2007, in consultation with the National Association of Insurance Commissioners, states with experience with long-term care insurance partnership plans, other state, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships which have benefits paid under such policies will be treated the same by all such states, and states with such partnerships shall be subject to such standards unless the state notifies the Secretary of the State's election to be exempt from such standards.

The Secretary annually reports to Congress on the long-term care insurance partnerships. Such reports would include analyses of the extent to which partnership programs expand or limit access of individuals to long-term care and the impact of such partnerships on federal and state expenditures under Medicare and Medicaid. Nothing in this provision shall require the Secretary

to conduct an independent review of each long-term care insurance policy offered under or in connection with a state partnership program.

A state plan amendment that provides for a qualified state long-term care insurance partnership may provide that the amendment be effective for long-term care insurance policies issued on or after a date that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

With respect to policy exchanges, Conferees expect existing policy holders will be able to exchange existing policies for Partnership policies in accordance with policy provisions and state law after a State's plan amendment is effective.

National Clearinghouse for Long-Term Care. The Secretary establishes a National Clearinghouse for Long-Term Care Information (this may be done through a contract or interagency agreement). The National Clearinghouse for Long-Term Care: 1) educates consumers with respect to the availability and limitations of Medicaid long-term care coverage, including state Medicaid eligibility and estate recovery requirements; 2) provides objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care; 3) provide contact information for additional objective sources on planning for long-term care services needs; and 4) maintain a list of states with state long-term care insurance partnerships.

In providing information to consumers on long-term care, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out for the National Clearinghouse for Long-Term Care $3 million for each of fiscal years 2006 through 2010.

Expanded Access to Home and Community-based Services for the Elderly and Disabled (Section 6022 of the Conference Agreement, no provision in the Senate Bill, and Section 3131 of the House Bill)**.**

Current law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region, and limit the number of waiver participants (resulting in a waiting list for services in many states).

Approval for a HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law, (hospital, nursing facility or ICF-MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

A HCBS waiver is generally approved for a 3- or 5-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS). In July 2003, there were 275 HCBS waivers nationwide in all states (except Arizona which offers HCBS services under a Section 1115 waiver).

Senate Bill

No provision.

House Bill

The House bill would allow states to cover a broad range of home and community-based services (HCBS) as an optional benefit under the state Medicaid plan *without* requiring a waiver. States would be able to define which HCBS services will be covered and could include any service authorized by federal law for existing HCBS waiver programs (as defined in Section 1915(c)(4)(B) of the Social Security Act). Similar to the existing HCBS waiver program, paying for an individual's room and board would not be permitted under this new benefit.

To qualify for this benefit the individual must meet the following criteria: 1) age 65 or older or disabled (as defined under the Medicaid state plan) but who is not an individual with a developmental disability, mental retardation or a related condition; 2) have had a determination that, but for the provision of such services, the individual would require the level of care provided in a hospital or nursing facility (the cost of which could be reimbursed under Medicaid); and 3) meet the Medicaid eligibility standards in effect in the state (which may include an approved Medicaid waiver) as of the date of enactment of this provision.

A state would be able to cover this benefit under the Medicaid state plan if certain conditions are met: 1) any state waiver or demonstration under Sections 1915 or 1115 of the Social Security Act with respect to such services for individuals described in this provision must have expired; and 2) the state must monitor and report to the Secretary of the Department of Health and Human Services (DHHS) on a quarterly basis the enrollment and expenditures for services provided under this option.

A state would not be required to comply with existing Medicaid requirements regarding the statewide availability of the service, the comparability of services, and the income and resource rules applicable in the community. A state may also limit the number of individuals who are eligible for services, establish waiting lists for the receipt of these services, and limit the amount, duration, and scope of services.

This section would be effective for home and community-based services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual's room and board. The state may provide this option to individuals *without* determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR.

States are required to establish *needs-based criteria* for determining an individual's eligibility for the HCBS option established by this provision, and the specific HCBS the individual will receive. The State must also establish needs-based criteria for determining

whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision.

The state is also required to submit to the Secretary a projection of the number of individuals to be served under the option, and may limit the number of individuals who are eligible for such services.

The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

A state is allowed to modify the needs-based criteria described above in the event that enrollment of individuals for the HCBS option exceeds projected enrollment. The state is not required to seek prior approval of the Secretary if the state wishes to modify the needs-based criteria, but must give the Secretary and the public at least 60 days notice of the proposed modification. If a state modifies the needs-based criteria, existing recipients of the HCBS optional state plan services will continue to be eligible to receive those services for at least 12 months beginning on the date the individual first received medical assistance for HCBS services. After such a modification, the state, at a minimum, must apply the level of care determination for hospitals, nursing facilities, and ICF-MRs that were in effect prior to the application of more stringent criteria.

The state is required to use an independent evaluation for determining an individual's eligibility for HCBS. The independent evaluation must include an assessment of the needs of the individual to: (1) determine a necessary level of services and supports consistent with the individual's physical and mental capacity; (2) prevent unnecessary or inappropriate care, and (3) establish an individualized care plan for the individual.

The assessment must include: (1) an objective evaluation of an individual's inability or need for significant assistance to perform two or more activities of daily living as defined in the Internal Revenue Service code; (2) a face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for HCBS; (3) where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual; (4) consultation with all treating and consulting health and support professionals caring for the individual; (5) an examination of the individual's relevant history and medical records, and care and support needs guided by best practices and research on effective strategies that result in improved health and quality of life outcomes. The assessment must also evaluate the ability of the individual or individual's representative to self-direct the purchase and control of HCBS if he/she elects this option, and if such an option is covered by the state.

The independent evaluation is to establish a written individualized plan of care. The plan must be developed in consultation with the individual, the individual's treating physician, health care or support professionals, or other appropriate individuals, and the family caregiver or individual representative if appropriate; (2) to take into account the extent, and the need for, any family or other supports for the individual; (3) to identify the HCBS services to be provided (or purchase, if the individual elects to self-direct his/her care); (4) to be reviewed at least annually or as needed when there is a significant change in circumstances.

States may allow individual (or the individual's representative) to elect to self-direct the purchase and control of state plan HCBS. Under the self-directed option, the individual's needs, preferences, and capabilities are assessed, and based on the assessment, a service plan is

developed jointly with the individual (or representative) that is approved by the state. The service plan must include certain activities such as a person-centered planning process and risk management techniques. States may also include an individualized budget that identifies a dollar value for the services and supports under the control and direction of the individual or his or her representative. States are required to provide information in the state plan amendment about how an individualized budget is developed and implemented.

The state must ensure that the provision of home and community-based services meets federal and state guidelines for quality assurance. The state must establish standards for the conduct of the independent evaluation to prevent conflicts of interest, and must allow for at least annual redetermination of eligibility and appeals using the process for appeals under the State Plan.

States may elect to provide for a period of presumptive eligibility (not to exceed 60 days) for individuals that the state has reason to believe may be eligible for home and community-based services. The covered activities include carrying out the independent evaluation and assessment and, if eligible, the specific services the individual will receive.

In covering this benefit, a state may elect not to comply with existing Medicaid requirements related to statewideness and the income and resource rules applicable in the community, but only for purposes of providing home and community-based services in accordance with this benefit. This option should not be construed as applying to those receiving Medicaid in an institution as a result of a determination that the individual requires the level of care in a hospital, nursing facility or ICF/MR.

Federal Medicaid funding will continue to be available for individuals who are receiving Medicaid in an institution or home and community-based setting (under a HCBS waiver program or Section 1115 demonstration) as of the effective date of the Medicaid state plan amendment, without regard to whether the individuals satisfy the more stringent eligibility criteria established under that paragraph until the individual is discharged from the institution or waiver program, or no longer requires such level of care.

The provision requires the Secretary acting through the Director of the Agency for Healthcare Research and Quality, to consult with consumers and health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction regarding HCBS offered under Medicaid.

The Secretary is required to use the indicators and measures to assess HCBS and outcomes, particularly with respect to a recipient's health and welfare, and the overall system for HCBS under Medicaid. The Secretary is also required to make best practices and comparative analyses of system features available to the public.

This provision will be effective on January 1, **2007.**

Optional Choice of Self-directed Personal Assistance Services (Cash and Counseling) (Section 6023 of the Conference Agreement, and no provision in the Senate Bill, and Section 3132 of the House Bill)**.**

Current law

Under current law, state Medicaid programs offer several types of long-term care services to individuals who, because of disability or chronic illness, need assistance with activities such as eating, bathing, and dressing. Medicaid programs have the option of covering personal care services and may also cover a broad set of other services through a home and community-based

(HCBS) waiver authorized under Section 1915(c) of the Social Security Act. To qualify for a HCBS waiver, the individual must require the level of care of a hospital, nursing facility or intermediate care facility for persons with mental retardation (ICF/MR).

Traditionally, Medicaid personal care and other related services have been provided to individuals through local public or private agencies. However, in the last decade, Medicaid beneficiaries with disabilities or chronic conditions and federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as "self-directed" or "consumer-directed" programs. The specific elements that a Medicaid beneficiary can control vary widely depending upon the state and the type of service covered. Currently, Medicaid law allows certain types of self-directed programs to be implemented through the normal Medicaid state plan and HCBS waiver process. Other types of self-directed programs require a research and demonstration waiver under Section 1115 of the Social Security Act.

Under the Medicaid personal care benefit, the Centers for Medicare and Medicaid Services (CMS) explicitly permits self-direction of personal care services. The CMS State Medicaid Manual specifies, "Medicaid beneficiaries may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider." However, the state Medicaid agency maintains responsibility for monitoring service delivery and ensuring that qualified providers are delivering the personal care services. The state is not permitted to provide Medicaid funds directly to a consumer to pay for the personal care services.

Generally, CMS policy has been that payments for personal care (or similar) services delivered by *legally responsible individuals* (e.g., the parent of a minor child or a spouse) are not eligible for federal Medicaid matching funds. However, CMS has recently amended its policy so that under a HCBS waiver (though not the Medicaid personal care benefit), states have the option of paying legally responsible relatives in extraordinary circumstances when the provision of personal care services is determined to be necessary to ensure the health and welfare of the waiver participant and so long as the parent or spouse meets the Medicaid provider requirements established by the state.

Senate Bill

No provision.

House Bill

This proposal would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The Secretary must not approve a state's self-directed personal assistance services program unless the state assures that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and that financial accountability exists for funds expended for these services.

The state must also evaluate the need for personal care under the Medicaid state plan or personal services under a HCBS waiver for individuals who 1) are entitled to Medicaid personal care under the state plan or receive HCBS waiver services; 2) may require self-directed personal assistance services; and 3) may be eligible for self-directed personal assistance services. If covered by the state and at the choice of the individual, those who are likely to require personal care or HCBS waiver services must be informed of the feasible alternatives in the provision of Medicaid personal care services or personal assistance services under a HCBS waiver. The state must also provide a support system that ensures participants in the program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

The state will be required to submit an annual report to the Secretary which includes the number of individuals served and total expenditures on their behalf, in the aggregate. The state must also provide an evaluation of overall impact on the health and welfare of participants compared to non-participants every three years.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Under this provision, the term "self-directed personal assistance services" means personal care and related services, or HCBS waiver services that are provided to an eligible participant. Individuals participating in such services will be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services.

At the election of the state, a participant will be allowed to 1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and 2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

An approved self-directed services plan and budget under this provision must meet the following requirements: 1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual's plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant's capacity to engage in activities that promote community life; respects the participant's preferences, choices and abilities; and involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

The budget for self-directed services and supports must be developed and approved by the state based on the assessment and plan (described above), and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access

to other medically necessary care and services furnished under the plan and approved by the state but not included in the budget

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual's resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity will be reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50%, though certain activities may be eligible for 75% reimbursement).

This provision will apply to apply to services furnished on or after January 1, 2006.

Conference Agreement

The conference agreement follows the House provision except that the effective date has been changed to January 1, 2007.

Authority to continue providing certain adult day health care services or medical adult day care services (No provision in Conference Agreement, Section 6039B of Senate Bill, and no provision in the House Bill)**.**

Current Law

Most states currently offer adult day care services to Medicaid beneficiaries through either the rehabilitation or clinic benefits of the Medicaid state plan (in about 8 states), or through a home and community-based (HCBS) waiver under Section 1915(c) of Medicaid law (in about 44 states through 102 separate HCBS programs).

Senate Bill

The Senate bill would prohibit the Secretary of HHS from denying federal Medicaid funding or withdrawing federal approval for adult day health care services or medical adult day care services under the Medicaid state plan, as defined by the state and approved by the Secretary on or before 1982.

House Bill

No provision.

Conference Agreement

No provision.

Limitation on Use of Contingency Fee Arrangements (Section 6031 of the Conference Agreement, Section 6022 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or human resources umbrella agency, will often contract with other public or private entities (e.g., other state agencies or departments, consulting firms) to perform various administrative functions. In some cases, contingency fee arrangements are used to pay contractors based on Medicaid dollars saved, recovered, or otherwise obtained for the state (e.g., a fee equal to 10% of third party liability collections). The federal reimbursement rate for most Medicaid administrative costs is 50%.

In determining the amount of administrative costs — including contingency fees — that may be eligible for federal reimbursement, states must comply with a number of federal statutes and regulations. In general, federal Medicaid law requires states to use methods of administration that are found by the Secretary of HHS to be necessary for the proper and efficient operation of their Medicaid programs. With regard to contingency fee contracts, guidance issued by the Centers for Medicare and Medicaid Services (CMS) to its regional offices in 2002 notes that in order to be eligible for federal reimbursement, contingency fees must: (1) be based on Medicaid cost avoidance savings or recoveries in which the federal government shares, (2) be intended to produce Medicaid program savings, not additional expenditures reported for federal reimbursement, and (3) not be contingent upon recoveries from the federal government. CMS guidance also notes that states may not claim federal reimbursement for contingency fee payments made to another government unit for Medicaid administrative activities.

Additional federal guidance is contained in Office of Management Budget (OMB) Circular A-87, which establishes principles and standards for determining allowable costs for states (and other governmental units) under federal grant programs such as Medicaid. The circular specifies that the cost of professional and consultant services are allowable when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government.

Senate Bill

Under the Senate bill, states would not be eligible for federal reimbursement of amounts expended in connection with a contract or agreement (other than a Medicaid managed care contract) between the state Medicaid agency (or any state or local agency that administers a portion of the Medicaid program) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet standards established by the Inspector General (IG) of HHS.

Such standards would be designed by the IG to ensure prudent purchasing and program integrity with respect to federal funds. The IG would annually review the standards and revise them as necessary to promptly address new compensation arrangements that may present a risk

to Medicaid program integrity. The standards would be issued no later than six months after enactment of the provision.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but compensation standards shall be established by the Secretary (rather than Inspector General) of HHS and reviewed as necessary (rather than annually).

Encouraging the Enactment of State False Claims Acts (Section 6032 of the Conference Agreement, Section 6023 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Under the federal False Claims Act, anyone who knowingly submits a false claim to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties of $5,500 to $11,000 for each false claim submitted. Under *qui tam* (whistleblower) provisions of the act, private citizens with knowledge of potential violations ("relators") may file suit on behalf of the government and are entitled to receive a share of the proceeds of the action or settlement of the claim (ranging from 15% to 30%, depending on whether or not the government elects to participate in the case).

States may have a variety of laws in place to facilitate prosecution of Medicaid fraud, and some have established their own versions of a false claims act. With limited exceptions, a state must repay the federal share (generally determined by the federal medical assistance percentage, or FMAP) of any provider overpayment within 60 days of discovering the overpayment, regardless of whether or not the state has recovered the overpayment.

Senate Bill

Under the Senate bill, if a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the federal medical assistance percentage, with respect to any amounts recovered under a state action brought under such a law, would be decreased by 10 percentage points.

The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS, in consultation with the Attorney General, to: (1) establish liability to the state

for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act, (5) contain provisions that are designed to prevent a windfall recovery for a *qui tam* relator that files a federal and state action for the same false or fraudulent claim.

The provision would be effective January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but excludes language regarding windfall recoveries for *qui tam* relators.

Employee Education About False Claims Recovery (Section 6033 of the Conference Agreement, Section 6024 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

No provision.

Senate Bill

Under the Senate bill, a state would be required to provide that any entity that receives annual Medicaid payments of at least $1 million, as a condition of receiving such payments, must: (1) establish written policies, procedures, and protocols for training of all employees of the entity, and of any contractor or agent of the entity, that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (4) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to such laws and the entity's policies and procedures for detecting fraud, waste, and abuse.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but applies only to entities receiving annual Medicaid payments of at least $5 million and does not require the establishment of protocols and procedures for training of employees (i.e., only written policies are required).

Prohibition on Restocking and Double Billing of Prescription Drugs (Section 6034 of the Conference Agreement, and Section 6025 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

No provision.

Senate Bill

The Senate bill would prohibit federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee). It would become effective on the first day of the first fiscal quarter beginning after enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Medicaid Integrity Program (Section 6035 of the Conference Agreement, Section 6026 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services (CMS) is the primary federal agency responsible for providing oversight of states' activities and facilitating their program integrity efforts. The HHS Office of Inspector General (OIG) also plays a role in Medicaid fraud and abuse detection and prevention efforts

through its investigations, audits, evaluations, issuances of program recommendations, and other activities.

As part of its program integrity activities, CMS operates a Medicare-Medicaid (Medi-Medi) data match project that analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation (e.g., providers submitting claims to both programs for procedures that add up to more than 24 hours of patient care in a single day). The Medi-Medi project began with one state in 2001, and was subsequently expanded to include eight others. It is primarily supported by "wedge" funds from the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (Medicare Part A) trust fund. HCFAC wedge funds are divided between the Department of Justice, the HHS Office of Inspector General, CMS, and other HHS agencies. The HCFAC account also funds the Medicare Integrity Program and activities of the Federal Bureau of Investigation related to health care fraud. Annual minimum and maximum HCFAC appropriations are specified in statute.

Senate Bill

The Senate bill would establish a Medicaid Integrity Program under title XIX. The Secretary of HHS would enter into contracts with eligible entities to carry out the program's activities, which would include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services furnished or for administrative services rendered, (3) identification and recovery of overpayments to individuals or entities receiving federal funds under Medicaid, (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity would be eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every five years, the Secretary of HHS — in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state officials with responsibility for controlling provider fraud and abuse under Medicaid — would establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse.

Appropriations for the Medicaid Integrity Program would total $50 million in FY2006, $49 million in each of FY2007 and FY2008, $74 million in each of FY2009 and FY2010, and $75 million in FY2011 and each fiscal year thereafter. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

A Medicaid Chief Financial Officer (CFO) and Medicaid Program Integrity Oversight Board would also be established under title XIX. The Medicaid CFO would be appointed by and would report directly to the Administrator of CMS. The duties and authority of the Medicaid CFO would be comparable to those of other CFOs with respect to the management and expenditure of federal funds under federal health care programs. A Medicaid Program Integrity Oversight Board would also be established by the Secretary of HHS. The duties and authority of the board would be comparable to those of the Medicare Contractor Oversight Board, and would include responsibility for identifying vulnerabilities and developing strategies for minimizing integrity risks to state Medicaid programs.

States would be required to comply with any requirements determined by the Secretary of HHS to be necessary for carrying out the Medicaid Integrity Program, or the duties of the Medicaid CFO and the Medicaid Program Integrity Oversight Board.

In each of fiscal years 2006 through 2010, $25 million would be appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). No later than 180 days after the end of each fiscal year (beginning with FY2006), the Inspector General of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

The Secretary of HHS would significantly increase the number of full-time equivalent CMS employees whose duties consist solely of ensuring the integrity of the Medicaid program.

House Bill

No provision.

Conference Agreement

The conference agreement generally follows the Senate bill, but excludes recovery of overpayments from the list of Medicaid Integrity Program activities and does not establish a Medicaid CFO or oversight board. It appropriates $5 million in FY2006, $50 million in each of FY2007 and FY2008, and $75 million in each fiscal year thereafter for Medicaid Integrity Program activities.

The conference agreement also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program under Title XVIII of the Social Security Act. The Secretary of HHS shall enter into contracts with eligible entities to ensure that the Medi-Medi Program is conducted for the purpose of: (1) identifying program vulnerabilities in Medicare and Medicaid through the use of computer algorithms to look for payment anomalies, (2) working with states, the Attorney General, and the Inspector General of HHS to coordinate appropriate actions to protect Medicare and Medicaid expenditures, and (3) increasing the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupment of fraudulent, wasteful, or abuse expenditures. At least quarterly, the Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of HHS, and the states.

In addition to HCFAC appropriations for the Medicare Integrity Program (which have a statutory floor and ceiling), the Medi-Medi Program would receive $12 million in FY2006, $24 million in FY2007, $36 million in FY2008, $48 million in FY2009, and $60 million in FY2010 and each fiscal year thereafter.

Enhancing Third Party Identification and Payment (Section 6036 of the Conference Agreement, Section 6021 of the Senate Bill, and Section 3144 of the House Bill)**.**

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered medical support (including health insurance) from noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (with certain exceptions, such as the Indian Health Service).

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities.

If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Senate Bill

The Senate bill would amend the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual.

In addition, it would require a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (2) accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the

state, (3) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided, and (4) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim

The provision would be effective January 1, 2006, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

The House bill is similar to the Senate bill.

Conference Agreement

The conference agreement generally follows the Senate and House bills, but substitutes the term "managed care organization" for "health maintenance organization" in Section 1902(a)(25) of the Social Security Act and specifies that states must require parties legally responsible for payment of a claim to provide, upon request of the state, information to determine during what period an individual or their spouses and dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary of HHS.

Chapter 4 – Flexibility in Cost Sharing and Benefits

State Option for Alternative Medicaid Premiums and Cost Sharing (Section 6041 of the Conference Agreement, no provision in the Senate Bill, and Sections 3121 and 3126 of the House Bill)**.**

Current Law

With some exceptions, premiums and enrollment fees are generally prohibited under Medicaid. When applicable, nominal amounts for such charges are between $1 and $19 depending on family income. States are allowed to establish nominal service-related cost-sharing requirements that are generally between $0.50 and $3, depending on the cost of the service provided. The regulations that specify nominal premium and service-related cost-sharing amounts were published and amended in the late 1970s and the early 1980s. These amounts are not adjusted by any factor. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules.

Under certain circumstances, families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL, medically needy groups, and workers with disabilities may be charged premiums for Medicaid coverage.

All service-related cost-sharing is prohibited for: (1) children under 18 years of age; (2) pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy; (3) services furnished to individuals who are inpatients in a

hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care; (4) services furnished to individuals receiving hospice care; (5) emergency services; and (6) family planning services and supplies. For most other beneficiaries and services, states may impose nominal service-related cost-sharing (described above). For workers with disabilities, service-related cost-sharing may be required that exceeds nominal amounts as long as they are set on a sliding scale based on income.

Under the state Medicaid plan, providers must not deny care or services to Medicaid beneficiaries due to the individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. For certain groups of pregnant women and infants for which monthly premiums may be charged, states must not require prepayment and must not terminate Medicaid eligibility for failure to pay such premiums until such failure continues for at least 60 days. States may waive those premiums when such payments would cause undue hardship.

States may offer Medicaid to certain uninsured women who are under age 65, and are in need of treatment for breast or cervical cancer based on screening services provided by an early detection program run by the CDC. This group has access to the same Medicaid services offered to the categorically needy in a given state, and are subject to Medicaid's nominal cost-sharing rules.

Senate Bill

No provision.

House Bill

The House Bill would allow states to impose premiums and cost-sharing for any group of individuals for any type of service, through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option would be allowed to vary among classes or groups of individuals, or types of service, including through the use of tiered cost-sharing for prescription drugs. Generally, the total amount of annual cost-sharing for all individuals in a family would be capped at 5% of family income for all families regardless of income. Individuals in families with income below 100% FPL would not be subject to premiums but could be subject to nominal service-related cost-sharing. Individuals in families with income exceeding 100% FPL may be subject to premiums and higher than nominal cost-sharing amounts.

Premiums would not be permitted for: (1) mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs. States may exempt additional groups from premiums.

Service related cost-sharing would not be permitted for: (1) services provided to mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided

to individuals receiving Medicaid hospice services; (5) services provided to individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; and (7) family planning services and supplies. States may exempt additional individuals or services from service-related cost-sharing.

In applying limits on cost-sharing amounts under this option that states may impose on individuals under 100% FPL, beginning with 2006, the Secretary would be required to increase nominal amounts of service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

The bill further specifies that these provisions would not prevent states from further limiting cost sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.

The bill would allow states to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. States may apply this provision to some or all groups of beneficiaries, and may waive premium payments in cases where such payments would be an undue hardship. In addition, the provision would allow states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition for the provision of care or services. Providers would also be allowed to reduce or waive cost-sharing amounts.

The Government Accountability Office (GAO) would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services. The report would be required to be submitted to Congress no later than January 1, 2008.

These provisions would apply to cost-sharing for items and services furnished on or after January 1, 2006.

The House bill also specifies that none of the proposed cost-sharing (or benefit) provisions described above would apply to women who qualify for Medicaid under the breast and cervical cancer eligibility group.

Conference Agreement

The conference agreement includes the House bill, with modifications. It clarifies that rules with respect to optional cost sharing for prescribed drugs (see below) are separate from the rules for other optional cost sharing. Explicit cost sharing limits for individuals in families with income under 100% FPL are dropped in the conference agreement. For individuals in families with income between 100 and 150% FPL: (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.

Two groups are added to the list of those exempt from paying premiums and cost-sharing under the House bill. In the conference agreement, these additional groups include (1) children in foster care who receive aid and assistance under Part B of Title IV (Child and Family Services) of the Social Security Act; and (2) women who qualify for Medicaid under the breast and cervical cancer eligibility group (a technical change from the House bill).

In addition, the agreement clarifies that providers could reduce or waive cost-sharing on a case-by-case basis.

Under the conference agreement, increases in the nominal cost-sharing amounts follow the House bill (i.e., annual adjustments using the medical CPI), but apply more broadly to existing cost-sharing provisions in statute (Section 1916) as well as to the new cost-sharing provisions in the House bill specific to prescription drugs and non-emergency care provided in an emergency room (described below).

Special Rules for Cost Sharing for Prescription Drugs (Section 6042 of the Conference Agreement, no provision in the Senate Bill, and Section 3122 of the House Bill)**.**

Current Law

States are allowed to establish nominal service-related cost-sharing requirements (defined in regulation) that are generally between $0.50 and $3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules. As with other Medicaid benefits, nominal cost-sharing may be imposed on prescribed drugs, and states may vary nominal cost-sharing amounts for preferred and non-preferred drugs. States may also implement prior authorization for prescribed drugs.

Senate Bill

No provision.

House Bill

The House bill would allow states to impose cost-sharing amounts that exceed the proposed state option limits described above for certain state-identified non-preferred drugs if the cost sharing plan meets the following characteristics. Under this option, states may impose higher cost-sharing amounts for non-preferred drugs within a class; waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such cost-sharing for preferred drugs to persons exempt from cost-sharing (identified above).

Cost-sharing for non-preferred drugs would be based on multiples of the nominal amounts based on family income. For persons with family income below 100% of FPL, nominal cost sharing would apply. For those with family income at or above 100% but below 150% of FPL, the multiple is equal to two times the applicable nominal amount, and for those with income equal to or exceeding 150% of FPL, the multiple is equal to three times the applicable

nominal amount. For persons generally exempt from cost-sharing (identified above), cost-sharing for non-preferred drugs may be applied. Such cost-sharing may not exceed nominal amounts, and aggregate caps on cost-sharing (in terms of nominal amounts and maximum cost-sharing based on the specified percentage of family income identified above) would still apply.

For Medicaid purposes, states would not be allowed to treat a preferred drug under the TRICARE pharmacy benefit program as a non-preferred drug, nor could states impose cost-sharing that exceeds the standards under this program that are in effect on the date of enactment for this provision.

In cases in which a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product.

The House bill would not prevent states from excluding specified drugs or classes of drugs from these special cost-sharing rules.

States would be prohibited from implementing these special cost-sharing rules for prescription drugs unless the state has instituted a system for prior authorization and related appeals processes for outpatient prescription drugs.

These provisions would become effective for cost-sharing imposed for items and services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement includes the House bill, with modifications. Cost-sharing for non-preferred drugs may not exceed: (1) nominal amounts for individuals in families with income below or equal to 150% FPL, and (2) 20% of the cost of the drug for individuals in families with income above 150% FPL.

The conference agreement also drops both the TRICARE and the prior authorization/appeals process provisions in the House bill. It also changes the effective date of these provisions to January 1, 2007.

Emergency Room Copayments for Non-Emergency Care (Section 6043 of the Conference Agreement, no provision in the Senate Bill, and Section 3123 of the House Bill)**.**

Current Law

Waivers may be used to allow states to impose up to twice the otherwise applicable nominal cost-sharing amounts for non-emergency services provided in a hospital emergency room (ER). States may impose these higher amounts if they have established that Medicaid beneficiaries have available and accessible alternative sources of non-emergency, outpatient services.

Senate Bill

No provision.

House Bill

The House bill would allow states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain conditions are met. First, alternative non-emergency providers must be available and accessible to the person seeking care. Second, after initial screening but before the non-emergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a higher copayment, (2) the name and location of an alternative non-emergency provider and that this provider and that a lower copayment may apply, and (3) the hospital can provide a referral. When these conditions are met, states could apply or waive cost-sharing for services delivered by the alternate provider.

For persons with income below 100% FPL, cost-sharing for non-emergency services in an ER could not exceed twice the nominal amounts. Individuals exempt from premiums or service-related cost-sharing under other provisions of this bill may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. Aggregate caps on cost-sharing established under this bill (described in Sec. 3121(a)) would still apply.

These provisions would have no impact on a hospital's obligations with respect to screening and stabilizing emergency medical conditions, nor would they modify the application of the prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization. In addition, no hospital or physician that makes a cost-sharing determination would be liable in any civil action or proceeding, absent a finding by clear and convincing evidence of gross negligence. Liabilities related to the provision of care (or failure to do so) would not be affected by these provisions.

"Non-emergency services" would mean any care or services furnished in an ER that the physician determines does not constitute an appropriate medical screening examination or stabilizing examination and treatment screening required for hospitals under Medicare law (regarding examination and treatment for emergency medical conditions and women in labor). "Alternative non-emergency services provider" would mean a Medicaid-participating health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider that provides clinically appropriate services for such diagnosis or treatment of the condition within a clinically appropriate time of the provision of such non-emergency services.

The Secretary would be required to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. The House bill also authorizes and appropriates $100 million for paying such providers for the 4-year period beginning with 2006. The Secretary would be required to give a preference to states that establish or provide for alternate non-emergency services providers (or networks) that serve rural or underserved areas where beneficiaries may have limited access to primary care providers, or in partnership with local community hospitals. To access these funds, states would be required to file an application meeting requirements set by the Secretary.

These amendments would apply to non-emergency services furnished on or after the date of enactment of this Act.

Conference Agreement

The conference agreement includes the House bill, with modifications. This provision allows states to permit a hospital to impose cost sharing for non-emergency care delivered in an ER under the same conditions identified in the House bill. But the conditions defining the beneficiary notification process are expanded to explicitly include a medical screening examination for emergency medical conditions as defined in Medicare law and a determination that such an emergency does not exist, prior to the delivery of non-emergency care in the ER. In addition, the hospital (not the physician or hospital) is responsible for the notification process.

The conference agreement clarifies that no hospital or physician can be held liable in any civil action or proceeding for the imposition of cost sharing under this new option, absent a finding of gross negligence by the hospital or physician. This provision does not affect liability with respect to examination and treatment for emergency medical conditions (including women in labor) as specified in Medicare law or otherwise applicable under state law based on the provision of (or failure to provide) care.

The conference agreement also slightly modifies the definition of an alternative non-emergency services provider by specifying that such providers be able to diagnose or treat a condition contemporaneously with (rather than within a clinically appropriate time of) the provision of similar non-emergency services that would be provided in an ER.

The conference agreement also changes the effective date of these provisions to January 1, 2007.

Use of Benchmark Packages (Section 6044 of the Conference Agreement, no provision in the Senate Bill, and Section 3124 of the House Bill)**.**

Current Law

Categorically needy (CN) eligibility groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. Some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

As described above, some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, FQHC services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children in CN groups are guaranteed access to all federally coverable routine and follow-up dental services necessary to treat a dental problem. EPSDT may be offered to MN children.

Both the services provided by rural health clinics (RHCs) and federally qualified health services (FQHCs) are required benefits for CN groups under Medicaid. Among other mandatory benefits for MN groups, states must offer ambulatory services for persons under 21 and those entitled to institutional services. Such ambulatory services may include RHC and FQHC services at state option. In general, RHCs and FQHCs are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services.

Senate Bill

No provision.

House Bill

The House bill would give states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage (described below). States could only apply this option to eligibility categories established before the date of enactment of this provision. States may choose to provide wrap-around and additional benefits.

Enrollment in benchmark and benchmark-equivalent coverage could be required for "full benefit eligible individuals," including persons eligible for all services covered for the CN, or any other category of eligibility for all covered services as determined by the Secretary. Certain individuals would be excluded from the definition of a full-benefit eligible, including (1) the MN; (2) CN individuals in certain states who are required to pay for medical expenses from their income until their remaining net income meets SSI financial standards in effect in 1972; and (3) other individuals who qualify for Medicaid when costs incurred for medical expenses or other remedial care are subtracted from income to meet financial eligibility requirements (also known as spend-down populations).

The House bill would require that specified groups be exempted from this option, including: (1) mandatory pregnant women and children; (2) dual eligibles (i.e., Medicaid beneficiaries also entitled to benefits under Medicare); (3) terminally ill persons receiving Medicaid hospice services; (4) individuals in medical institution who are required, as a condition

of receiving institutional care, to pay for costs of medical care except for a minimal amount retained from their income for personal needs; (5) individuals who are medically frail or who have special medical needs, as identified in accordance with regulations of the Secretary; and (6) individuals who qualify for Medicaid long-term care services (i.e., nursing facility services, a level of care in any institution equivalent to nursing facility services, home and community-based waiver services, home health services, home and community care for functionally disabled elderly individuals, personal care, and other optional long-term care services offered by the state).

Benchmark and benchmark-equivalent packages would be nearly identical to those offered under SCHIP, with some additions. Benchmark coverage would include: (1) the standard Blue Cross/Blue Shield preferred provider plan under FEHBP; (2) health coverage for state employees; and (3) health coverage offered by the largest commercial HMO. Benchmark-equivalent coverage would have the same actuarial value as one of the benchmark plans. Such coverage would include: (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) well child care, including immunizations, and (5) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services. Determination of actuarial value would follow generally accepted actuarial principles and methodologies and would be conducted by a member of the American Academy of Actuaries.

Both benchmark and benchmark-equivalent coverage would include "qualifying child benchmark dental coverage." A qualifying child would include individuals under 18 with family income below 133% FPL. Benchmark dental coverage would be equivalent to or better than the dental plan that covers the greatest number of individuals in the state who are not eligible for Medicaid.

States could only enroll eligible beneficiaries in benchmark and benchmark-equivalent coverage if such persons have access to services provided by RHCs and FQHCs, and the Medicaid prospective payment system for both types of providers remains in effect.

These provisions would be effective upon the date of enactment.

Conference Agreement

The conference agreement includes the House bill, with modifications. For any child under age 19 in one of the major mandatory and optional eligibility groups (defined in Section 1902(a)(10)(A)) under the state Medicaid plan, wrap-around benefits to the benchmark or benchmark-equivalent coverage consists of early and periodic screening, diagnostic and treatment services as defined in current Medicaid law. The agreement drops benchmark dental coverage and accompanying provisions defining the children who would qualify for such benchmark dental coverage.

Also, under the conference agreement, states may exercise this option only for eligibility groups that were established under the state plan before the date of enactment of this option.

The conference agreement drops mandatory children under 18 (under Section 1902(a)(10)(A)(i)) from the list of groups exempted from this option.

The conference agreement also expands the list of specified groups that would be exempted from benchmark coverage to include: (1) individuals who qualify for Medicaid under the state plan on the basis of being blind or disabled regardless of whether the individual is eligible for SSI on such basis, including children with disabilities that meet SSI disability standards who require institutional care, but for whom care is delivered outside the institution, and the cost of that care does not exceed the otherwise applicable institutional care (also known as Katie Beckett or TEFRA children); (2) children in foster care receiving child welfare services (under Part B of Title IV) and children receiving foster care or adoption assistance under Part E of Title IV without regard to age; (3) individuals who qualify for Medicaid on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date); (4) women in the breast and cervical cancer eligibility group (a technical change from the House bill); and (5) other "limited services beneficiaries," including certain tuberculosis-infected individuals, and legal and undocumented non-citizens who meet the financial and categorical requirements for Medicaid eligibility without regard to time in the U.S. and are eligible only for emergency medical services.

The conference agreement also adds to the set of three benchmark benefit packages, a fourth option called "secretary approved coverage" which may include any other health benefits coverage that the Secretary determines will provide appropriate coverage for the population targeted to receive such coverage.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Chapter 5 – State Financing Under Medicaid

Managed Care Organization Provider Tax (Section 6051 of the Conference Agreement, and Section 6033 of the Senate Bill, and Section 3142 of the House Bill)**.**

Current Law

States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based." A broad-based tax is a tax that is uniformly applied to all providers or services within the provider class. The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based.

Medicaid managed care organizations (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians — are not restricted to Medicaid providers or Medicaid services.

Senate Bill

The Senate bill would expand the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both

Medicaid and non-Medicaid MCOs. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based.

The provision would become effective on January 1, 2006 except in States that have, as of December 31, 2005, a tax on the Medicaid MCO class of providers as defined under current law. The provision would not apply to those states.

House Bill

Similar to Senate provision except the provision would become effective upon enactment except for in states with taxes based on the current law Medicaid MCO provider class. For those states, the prohibition would become effective on October 1, 2008 and the reduction in Medicaid reimbursement due to this provision would be 50% for the fiscal year beginning on that day.

Conference Agreement

The conference agreement expands the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. The provision becomes effective upon enactment except in states with taxes based on the current law Medicaid MCO provider class as of December 8, 2005. In those states, the provision becomes effective on October 1, 2009.

Reforms of Case Management and Targeted Case Management Services (Section 6052 of the Conference Agreement, and Section 6031 of the Senate Bill, and Section 3146 of the House Bill)**.**

Current Law

Under current Medicaid law (Section 1915(g)(2) of the Social Security Act), case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. Case management services are an optional benefit under the Medicaid state plan. The term "targeted case management" (TCM) refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of Medicaid eligible individuals as defined by the state (e.g., those with chronic mental illness), or persons who reside in a specific area.

Several states extend the Medicaid TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care – defined in the Medicaid state plan as "children in the state's custody and who are placed in foster homes." As part of the foster care program, children receive certain case management services regardless of whether or not they are a Medicaid beneficiary.

In addition, the existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary. The State Medicaid Manual (Section 4302.2) states that claims for targeted case management services must be fully documented for a

specific Medicaid beneficiary in order to receive payment. In addition, documentation that includes time studies and cost allocation plans "are not acceptable as a basis for Federal participation in the costs of Medicaid services." Cost allocation plans are a narrative description of the procedures that a state agency uses in identifying, measuring, and allocating the state agency's administrative costs incurred for supervising or operating programs. Per federal regulations (45 CFR 95.505), the cost allocation plan does not include payments for services and goods provided directly to program recipients. However, a State Medicaid Director's (SMD) letter dated January 19, 2001, which discusses targeted case management services for children in foster care under the federal Title IV-E program, requires states to "properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program." Thus, this letter extended the application of cost allocation plans to claim reimbursement for case management services when a child is receiving these services under both the Title IV-E (foster care) and Medicaid programs.

Senate Bill

This proposal would further define the Medicaid TCM benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.

Specifically, the proposal would clarify that the TCM benefit includes the following: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The proposal would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would *not* include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would *not* cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

This provision would take effect January 1, 2006.

House Bill

Same as Senate provision.

Conference Agreement

The conference agreement modifies the Senate and House bills to differentiate between *case management* and *targeted case management services*. It would define case management services in federal law as services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services including: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The conference agreement also establishes those activities that are not reimbursable as case management services including the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. With respect to the direct delivery of foster care services, case management would not include research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

The term 'targeted case management services' is defined as case management services that are provided to specific classes of individuals or to individuals who reside in specific areas.

In cases where a case management provider contacts individuals who are not Medicaid eligible, or who are not part of the TCM target population, the activity could be billed as case management services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as case management services.

Consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for case management (or TCM) services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. If case management (or TCM) services are reimbursable by another federally-funded program the state would be required to allocate the costs of these services using OMB Circular A-87 (or any related or successor guidance or regulations).

Finally, the conference agreement established that (1) nothing in the provision would affect the application of rules with respect to third party liability under programs or activities carried out under Title XXVI of the Public Health Service Act (the HIV Health Care Services Program) or the Indian Health Service; and (2) the Secretary would be required to promulgate

regulations to carry out the changes made by this provision. The effective date of this provision would be January 1, 2006.

Additional FMAP Adjustments (Section 6053 of the Conference Agreement, Sections 6032 and 6037 of the Senate Bill, and Sections 3148 and 3205 of the House Bill)**.**

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under the State Children's Health Insurance Program (SCHIP), subject to the availability of funds from a state's SCHIP allotment. In addition to Medicaid and SCHIP, the FMAP is used in determining federal reimbursement for a number of other programs, including foster care and adoption assistance under Title IV-E of the Social Security Act.

When state FMAPs are calculated by HHS for an upcoming fiscal year, the state and U.S. amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). For example, to calculate FMAPs for FY2006, HHS used per capita personal income data for 2001, 2002, and 2003 that became available from BEA in October 2004.

BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised Census Bureau population figures and newly available source data. It also undertakes a comprehensive data revision — reflecting methodological and other changes — every few years that may result in upward and downward revisions to each of the component parts of personal income, which include: wages and salaries, supplements to wages and salaries (such as employer contributions for employee pension and insurance funds), proprietors' income, and dividends, interest, and rent.

As a result of these annual and comprehensive revisions, it is often the case that the value of a state's per capita personal income for a given year will change over time. For example, the 2001 per capita personal income data published by BEA in October 2003 (used in the calculation of FY2005 FMAPs) differed from the 2001 per capita personal income published in October 2004 (used in the calculation of FY2006 FMAPs).

P.L. 106-554 (Consolidated Appropriations Act, 2001), provided that for fiscal years 2001 through 2005, the Medicaid and SCHIP FMAPs for Alaska would be calculated using the state's per capita income divided by 1.05. Dividing by 1.05 lowered the state's per capita income, thereby increasing its FMAP.

Senate Bill

Under the Senate bill, FY2006 FMAPs for Medicaid and SCHIP would be re-computed for all states so that no FY2006 FMAP would be less than the greater of: (1) a state's FY2005 FMAP minus 0.5 percentage points (0.1 in the case of Delaware and Michigan, 0.3 in the case of

Kentucky) or (2) the FY2006 FMAP that would have been determined for a state if per capita incomes for 2001 and 2002 that were used to calculate the state's FY2005 FMAP were used.

In a separate provision, if Alaska's calculated FY2006 or FY2007 FMAP for Medicaid or SCHIP is less than its FY2005 FMAP, the FY2005 FMAP would apply.

House Bill

Under the House bill, for purposes of computing Medicaid FMAPs beginning with FY2006, employer contributions toward pensions that exceed 50% of a state's total increase in personal income for a period would be excluded from the per capita income of a state, but not from U.S. per capita income.

In a separate provision, for purposes of computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their incomes.

Conference Agreement

The conference agreement follows the Alaska provision in the Senate bill and the Katrina provision in the House bill.

DSH Allotment for the District of Columbia (Section 6054 of the Conference Agreement, and Section 6035 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment.

Senate Bill

The Senate bill would raise the allotments for the District of Columbia for FY 2000, 2001, and 2002 from $ 32 million to $ 49 million. The higher allotments would be used to calculate DSH allotments beginning with FY 2006 amounts. The provision would take effect as if enacted on October 1, 2005 and would apply to expenditures made on or after that date.

House Bill

No provision.

Conference Agreement

The conference agreement includes a provision similar to the Senate provision. The agreement clarifies that the increased amounts calculated based on the modified allotments for FY 2000, 2001, and 2002 only apply to DSH expenditures applicable to fiscal year 2006 and subsequent fiscal years that are paid on or after October 1, 2005.

Increase in Medicaid Payments to Insular Areas. (Section 6055 of the Conference Agreement, no provision in the Senate Bill, and Section 3141 of the House Bill)**.**

Current Law

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. For fiscal year 1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The federal Medicaid matching rate, which determines the share if Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.

Senate Bill

No provision.

House Bill

For each of fiscal years 2006 and 2007, the House bill would increase the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa. Puerto Rico would not receive additional federal Medicaid funding from this provision.

For the Virgin Islands and Guam, the FY2006 total annual Medicaid caps would be increased by $2.5 million and the FY2007 caps would be increased by $5.0 million. For the Northern Marianas, the FY2006 total annual Medicaid cap would be increased by $1.0 million and the FY2007 cap would be increased by $2.0 million. For American Samoa, the FY2006 total annual Medicaid cap would be increased by $2.0 million and the FY2007 cap would be increased by $4.0 million. For fiscal year 2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the FY2007 ceiling, as modified by this provision, by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics).

Conference Agreement

The conference agreement follows the House bill.

Demonstration Project Regarding Medicaid Coverage of Low-income HIV-infected individuals (No provision in the Conference Agreement, Sec. 6039 (c) of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Section 1115 gives the Secretary of HHS authority to modify virtually all aspects of the Medicaid (and SCHIP) programs. Among other projects, the Secretary has used the Section 1115 waiver authority to approve benefit-specific demonstrations that provide targeted services to certain individuals. For example, under existing Medicaid HIV/AIDS Section 1115 demonstration waivers, the Secretary approved programs that provide a limited set of Medicaid benefits (e.g., case management, and pharmacy services) to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan for purposes of federal reimbursement. Project costs associated with waiver programs granted under the Medicaid (or SCHIP) programs are subject to that state's FMAP (or enhanced-FMAP). Unlike regular Medicaid (or SCHIP), CMS waiver guidance specifies that costs associated with waiver programs must be budget neutral (or allotment neutral) to the federal government over the life of the waiver program whereby the federal and state government negotiate a spending cap beyond which the federal government has no fiscal responsibility.

Senate Bill

The Senate Bill would require the Secretary of HHS to allow states to seek approval for time limited (i.e., 5-year) Section 1115 demonstration projects that provide full Medicaid coverage to specified HIV-infected individuals. For fiscal years 2006 through 2010, $450,000,000 in federal funds would be appropriated for such demonstrations. From this amount, the Secretary would allocate money to states and territories (without regard to existing federal Medicaid spending caps applicable in the territories) with approved HIV Section 1115 demonstrations based on the availability of such funds. Allotment of funds among states (or territories) with approved demonstrations would be based on an amount equal to the state's SCHIP Enhanced Federal Medical Assistance Percentage (Enhanced-FMAP) for quarterly expenditures associated with medical assistance provided to individuals under the waiver up to the specified cap. The Secretary would be required to submit a program evaluation to Congress not later than December 31, 2010. This provision would be effective on January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include the Senate bill.

Inclusion of Podiatrists As Physicians (no provision in the Conference Agreement, Section 6034 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Under Medicaid, services provided by podiatrists may be covered under the optional "other practitioners" benefit category. "Physician services" are a mandatory Medicaid benefit.

Senate Bill

The Senate bill would treat podiatrists as physicians, as is the case under Medicare. Thus, states would be required to cover the medical services of podiatrists (i.e., doctors of podiatric medicine) under Medicaid. This provision would apply to all such services furnished on or after January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Demonstration Project Regarding Medicaid Reimbursement for Stabilization of Emergency Medicaid Conditions by Non-Publicly Owned or Operated Institutions for Mental Diseases (no provision in the Conference Agreement, Section 6036 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The 1950 amendments to the Social Security Act established the prohibition of federal assistance for IMD residents as well as for patients diagnosed with a psychosis found in other medical institutions. When Medicaid was established in 1965, the law included a state option to allow Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to residents age 65 years and older in IMDs. The 1972 amendments allowed for optional coverage, under certain circumstances, for IMD residents under age 21 or, in some cases, under age 22. In general, reimbursement for services obtained in IMDs by Medicaid beneficiaries ages 22 to 64 years remains prohibited. The term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Under Medicare, "emergency medical condition" means a medical condition with acute symptoms of sufficient severity such that the absence of immediate medical attention could result in (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any organ. Under Medicare, the term "stabilize" means medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Senate Bill

The Senate bill would require the Secretary to establish a 3-year demonstration project in eligible states to provide Medicaid coverage for certain IMD services (not publicly-owned or operated) for Medicaid eligible individuals who are between the ages of 21 and 64, and who require IMD services to stabilize an emergency medical condition. Upon approval of an application, eligible states would include Arizona, Arkansas, Louisiana, Maine, North Dakota, Wyoming, and four additional states to be selected by the Secretary to provide geographic diversity. The provision would appropriate $30 million for FY2006 for the demonstration which would be available through December 31, 2008. The Secretary would allocate funds to eligible states based on their applications and the availability of funds. Payments to states would be drawn from these allocations, based on the federal matching rate (FMAP) for benefits.

For purposes of the demonstration, the Secretary would be required to waive current law limitations on payments for services delivered to persons under 65 who are patients in an IMD. The Secretary would have the option to also waive other requirements in Sections XI and XIX, including requirements relating to statewideness and comparability of benefits, only to the extent necessary to carry out the demonstration project. The terms "emergency medical condition" and "stabilize," as defined under Medicare, would apply to the demonstration described in this provision.

The Senate bill would also require the Secretary to submit annual reports to Congress on the progress of the demonstration project. No later than March 31, 2009, the Secretary would submit to Congress a final report describing whether the demonstration: (1) resulted in increased access to Medicaid inpatient mental health services, (2) produced a significant reduction in the use of higher cost emergency room services for Medicaid beneficiaries, (3) impacted the costs of providing Medicaid inpatient psychiatric care, and (4) should be continued after December 31, 2008, and expanded nationwide.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Chapter 6 – Other Provisions

Subchapter A – Family Opportunity Act

Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children (Section 6062 of the Conference Agreement, Section 6042 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. For some of these groups, disability status or medical need is directly related to Medicaid eligibility (e.g., children receiving SSI with family income below 75% FPL). But there are other pathways through which such children may qualify for Medicaid coverage for which disability status and/or medical need are irrelevant (e.g., children under age 6 with family income below 133% FPL). All of the Medicaid eligibility pathways for children require income levels that are generally below 300% of the federal poverty level (FPL) with some state-specific exceptions.

States may require Medicaid beneficiaries to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do so (defined below). This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child's continuing eligibility for Medicaid. If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for Medicaid. Third party liability rules apply to coverage in a group health plan; that is, such plans, not Medicaid, must pay for all covered services under the plan. Cost-effectiveness means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan.

For certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. States are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to children under 18 (up to age 21, or reasonable subcategories, at state option). Also, in certain circumstances, states may impose monthly premiums for Medicaid. For example, states may require certain workers with disabilities to pay premiums and cost-sharing set on a sliding scale based on income. For one of these groups, states may require those with income between 250% and 450% FPL to pay the full premium. But the sum of such payments may not exceed 7.5% of income. For other groups, states may not require prepayment of premiums and may not terminate eligibility due to failure to pay premiums, unless such failure continues for at least 60 days. States may also waive premiums when such payments would cause undue hardship.

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to 133 and 1/3% of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP statute are defined as those who would not qualify for Medicaid under the state plan in effect on

March 31, 1997. Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP authority are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are drawn from annual SCHIP allotments. The SCHIP E-FMAP builds on the Medicaid FMAP. The FMAP formula is designed to provide a higher federal matching rate for states with lower average per capita income, compared to the national average.

Senate Bill

The Senate bill would create a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the severity of disability required under the Supplemental Security Income (SSI) program with family income that exceeds SSI financial standards but is below 300% FPL. Medicaid coverage would be phased in by age group, beginning with children through age 6 in the second through fourth quarters of FY2008, then covering children through age 12 beginning in FY2009, and finally, covering children through age 18 during FY2010 and thereafter.

The Senate bill would require states to require certain parents of children eligible for Medicaid under the new optional coverage group to enroll in family coverage through employer-sponsored insurance (ESI) if certain conditions are met. When the employer offers family coverage, the parent is eligible for such coverage, and the employer contributes at least 50% of the total cost of annual premiums for such coverage, states must require participation in such coverage as a condition of continuing Medicaid eligibility for the child. Also, if such coverage is obtained, states must reduce premiums by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability. States could pay any portion of required premiums on behalf of eligible children under such plans. Medicaid would be the secondary payer to these ESI plans. Benefits offered by Medicaid but not offered by the ESI plans would be covered under Medicaid.

States would be permitted, within certain limits, to require families with children that qualify for Medicaid under the new optional eligibility category to pay monthly premiums on a sliding scale based on income, but only if specific caps on aggregate payments for cost-sharing (premiums plus other charges) for employer-sponsored family coverage are met. These caps specify that cost-sharing would not exceed 5% of income for families with income up to 200% FPL, and would not exceed 7.5% of income for families with income between 200% and 300% FPL. States could not require prepayment of premiums, nor would states be allowed to terminate eligibility of an enrolled child for failure to pay premiums unless lack of payment continues for a minimum of 60 days beyond the due date. States could waive payment of premiums when such payment would cause undue hardship.

The Senate bill would permit the income level for the new optional coverage group (set at 300% FPL) to exceed the otherwise applicable AFDC-related income standard for children under Medicaid. This section also stipulates that children with disabilities made eligible for Medicaid through the new optional coverage group would not be considered to be targeted low-income children as defined under SCHIP. Thus, the regular Medicaid FMAP, rather than the higher SCHIP E-FMAP, would apply for determining the federal share of Medicaid expenditures for the new optional coverage group. In addition, federal payments would be drawn from the open-ended Medicaid account and not the capped SCHIP account.

These provisions would be effective for items and services furnished on or after January 1, 2008.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill, with modifications. First, the agreement defines qualifying children as those considered disabled under the SSI program without regard to any income or asset eligibility requirements that apply under SSI for children and whose family income does not exceed 300 % FPL. In addition, the agreement moves up the start date by one year for phasing in Medicaid coverage for this new group. That is, Medicaid coverage would be phased in, beginning with children through age 6 in the second through fourth quarters of FY2007 (rather than FY2008), then covering children through age 12 beginning in FY2008 (rather than FY2009), and finally, covering children through age 18 beginning in FY2009 (rather than FY2010) and thereafter.

As under the Senate bill, the conference agreement allows states to impose income-related premiums under this option. But the agreement changes the aggregate amount of cost sharing for families based on income levels.

For children in families with income that does not exceed 200% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing cannot exceed 5% of family income. For children in families with income between 200% FPL and **300**% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing cannot exceed 7.5% of family income.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Demonstration Projects Regarding Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children (Section 6063 of the Conference Agreement, Section 6043 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allows states to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation (ICF-MR). Federal approval for these waivers is contingent on the state's documentation of the waiver's cost-neutrality. Cost-neutrality is met if, on average, the per person cost with the HCBS waiver is no higher than the cost if the person were residing in a hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

For children with psychiatric disabilities, many states provide Medicaid funding for inpatient psychiatric residential treatment facilities. However, because the waiver cost-neutrality calculation does not allow a comparison of HCBS waiver expenditures to expenditures in these psychiatric residential treatment facilities, most states have had difficulty covering HCBS waiver services for children with psychiatric disabilities. Four states (Indiana, Kansas, New York and Vermont) have been able to offer HCBS waiver services for children with psychiatric disabilities by documenting the cost-neutrality of the waiver compared to the state's hospital expenditures. However given the cost-neutrality requirement, those states that have limited the use of hospitals for children with psychiatric disabilities may be unable to develop HCBS waivers for this population.

Senate Bill

The Senate bill would authorize the Secretary to conduct demonstration projects in up to 10 states during the period from FY2007 through FY2011 to test the effectiveness of improving or maintaining the child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. These demonstration projects will develop home and community-based services as an alternative to a psychiatric residential treatment facility. However, these projects must also follow the requirements of the HCBS waiver program. Specifically, demonstration participants would be required to meet the level of care of a psychiatric residential treatment facility, and the average, per-person project expenditures may not exceed the average, per-person cost of a psychiatric residential treatment facility.

The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.

As part of the demonstration, the following conditions would apply: (1)projects must meet the same terms and conditions that apply to all HCBS waivers; (2) the Secretary must ensure that the projects are budget neutral; that is, total Medicaid expenditures under the demonstration projects will not be allowed to exceed the amount that the Secretary estimates would have been paid in the absence of the demonstration projects; and (3) applications for a demonstration project must include an assurance to conduct an interim and final evaluation by an independent third party and any reports that the Secretary may require.

This proposal would appropriate $218 million for FY2007 through FY2011 for the state demonstration projects and the federal evaluations and report. Total expenditures for state demonstration projects would not be allowed to exceed $21 million in FY2007, $37 million in FY2008, $49 million in FY2009, $53 million in FY2010, and $57 million in FY2011. Funds not expended in a given fiscal year would continue to be available in subsequent fiscal years. An additional $1 million would be available to the Secretary to complete a *required* interim and final evaluation of the project and report the conclusions of the evaluations to the President and Congress within 12 months of completing these evaluations.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision.

Development and Support of Family-to-family Health Information Centers (Section 6064 of the Conference Agreement, Section 6044 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, the Department of Health and Human Services (HHS) has awarded approximately $6.9 million to develop these information centers in 36 states under various program authorities including: (1) Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA); (2) the Real Choice Systems Change grant program operated by the Centers for Medicare and Medicaid Services (CMS); and (3) a one-year direct Congressional appropriation to an organization in Iowa. Federal funding for these projects is time-limited. Except for the one-year direct appropriation, state projects have generally been funded for a three or four-year period. HRSA intends to fund additional family-to-family health information centers awarding up to $2.4 million to six projects for a four-year period starting in FY2006.

Senate Bill

The Senate bill would increase funding under the SPRANS program of Title V of the Social Security Act for the development and support of new family-to-family health information centers (described below). This proposal would appropriate an additional $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009 for this new purpose. For each of fiscal years 2010 and 2011, the bill would authorize to be appropriated to the Secretary $5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between families of such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals. The family-to-family health information center would be staffed by families who have expertise in public and private health care systems and by health professionals.

The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision.

Restoration of Medicaid Eligibility for Certain SSI Beneficiaries (Section 6065 of the Conference Agreement, Section 6045 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

SSI and Medicaid eligibility is effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date that the individual is determined eligible.

Senate Bill

The Senate bill would extend Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date SSI eligibility was granted. This provision would be effective one year after the date of enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill provision.

Subchapter B — Money Follows the Person Rebalancing Demonstration

Money Follows the Person Rebalancing Demonstration (Section 6071 of the Conference Agreement, Section 6061 of the Senate Bill, and no provision in the House Bill)**.**

Current law

Under Medicaid, states can offer a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered

statewide as part of the Medicaid state plan (e.g., home health services and personal care services). Other services may be offered through a home and community-based services (HCBS) waiver under Section 1915(c) of the Social Security Act. These waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise require the level of care provided in certain types of institutions (i.e., a hospital, nursing facility or intermediate care facility for individuals with mental retardation (ICF-MR)). For example, HCBS waiver services could include respite, personal care, adult day care, or therapy. As part of the HCBS waiver, states have the ability to define the specific services that will be offered, to target a specific population (e.g., elderly individuals) and to limit the number of individuals who can participate in the waiver.

Approval for an HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if the average per person cost under the HCBS waiver is no higher than the average per person cost of receiving care in a hospital, nursing facility or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

Under current law, Medicaid beneficiaries who are residents of an institution (such as a nursing home) and who would like to leave that institution would be entitled to receive those Medicaid services covered by the Medicaid state plan. However, individuals may not be able to access the broader range of services under an HCBS waiver because many states have waiting lists for the waiver.

Medicaid expenditures for services (including the Medicaid state plan and HCBS waiver) are generally shared between the federal and state governments. In FY2003 (the latest expenditure data available), the federal government covered 59% of the cost of services; states covered the remaining 41% of expenditures. The specific federal share of a state is based on the state's federal medical assistance percentage (FMAP) rate which can range from 50% to 83%.

Senate Bill

The Senate provision would authorize the Secretary to conduct a demonstration project in states to increase the use of home and community-based care instead of institutions. States awarded a demonstration would receive 90% of the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community-based long-term care program, as described below.

Individuals will be eligible to participate in the demonstration if they meet the following criteria: they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); they are receiving Medicaid benefits for the services in this facility; and they will continue to require the level of care of the facility but for the provision of HCBS services.

The state's application for a demonstration project will be required to include, at a minimum, the following information: (1) assurance that the project was developed and will be operated through a public input process; (2) assurance that the project will operate in conjunction with an existing Medicaid home and community-based program; (3) the duration of

the project, which must be for at least two consecutive fiscal years in a five-year period starting in FY2009; (4) the service area, which may be statewide or less-than-statewide; (5) the target groups and the projected number to be enrolled and the estimated total expenditures for each fiscal year; (6) assurance that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible; (7) information on recent Medicaid expenditures for long-term care and home and community-based services and proposed methods to increase the state's investment in home and community-based services; (8) methods the state will use to eliminate barriers to paying for long-term care services for participants in the setting(s) of their choice; (9) assurance that the state will meet a maintenance of effort for Medicaid HCBS expenditures and will continue to operate a HCBS waiver that meets the statutory requirements for cost-neutrality.

A state will also be required to describe a plan for quality assurance and improvement of HCBS services under Medicaid; any requested waivers of Medicaid law; if applicable, the process for participants to self-direct his or her own services (meeting standards outlined in this proposal); and compliance with reports and evaluation, as required by the Secretary.

In addition to evaluating the merits of a state's application, in selecting demonstration projects, the Secretary will be required to consider a national balance of target groups and geographic distribution and to give a preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary will be authorized to waive certain sections of Medicaid law to achieve the purpose of the demonstration.

To qualify for grant awards after year one, states will be required to meet numerical benchmarks measuring the increased investment in services under this proposal and the number of individuals transitioned into the community. States will also be required to demonstrate that they are assuring the health and welfare of project participants. For states that do not meet these requirements, the Secretary will be required to rescind the grant award for future grant periods and will be allowed to re-award unused funding.

The proposal would require the Secretary to provide technical assistance and oversight to state grantees and may use up to $2.4 million of the amounts appropriated for the portion of fiscal year 2009 that begins on January 1, 2009, and ends on September 30, 2009, and for fiscal year 2010, to carry out these activities during the period beginning on January 1, 2009 and ending on September 30, 2013. The Secretary would also be required to conduct a national evaluation and report its findings to the President and Congress no later than September 30, 2012 and may use up to $1.1 million each year from FY2010 through FY2013 to carry out these activities.

This proposal would appropriate $250 million for the portion of FY2009 which begins on January 1, 2009, and ends on September 30, 2009; $300 million in FY2010; $350 million in FY2011; $400 million in FY2012; and $450 million in FY2013 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2013.

Payments for home and community-based long-term care services under the demonstration project would be in lieu of payment with respect to expenditures that could otherwise be paid for by Medicaid. However, if a state exhausts its grant funding in a particular year, the state is not prevented from using Medicaid to pay for home and community-based long

term care services. Finally, a state that does not use all of its funding in a given fiscal year will continue to have access to that funding for four subsequent fiscal years.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision, but makes several changes to the Senate bill. First, to be eligible an individual must continue to require the level of care in an institution. However, in any case where a state would apply a more stringent level of care standard as a result of implementing a Medicaid state plan option under section 1915(I), established under this conference agreement, the individual must continue to require the level of care which had resulted in admission to the institution.

A state must assure that it will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible. If the state chooses to apply a more stringent level of care as a result of covering the state plan option under Section 1915(I), established under this conference agreement, the individual must continue to meet the requirement for the level of care that had resulted in his or her admission to the institution.

In addition, those states awarded a demonstration would receive an enhanced FMAP rate (referred to as the "MFP-enhanced FMAP") equal to the current FMAP rate for the state increased by a number of percentage points equal to 50% of the difference between 100% and the normal FMAP rate. However, in no case can the FMAP rate exceed 90% for a state. The state will receive the MFP-enhanced FMAP for the costs of home and community-based, long-term care services for 12 months following a demonstration participant's transition from an institution into the community.

Finally, demonstration grants would be awarded starting in 2007, instead of 2009 which changes all relevant dates within this provision including:

- The duration of the project must be for at least two consecutive fiscal years in a five-year period starting in FY2007; and
- The Secretary would be able to use up to $2.4 million of the amounts appropriated for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, to carry out technical assistance and quality assurance activities during the period beginning on January 1, 2007 and ending on September 30, 2011; and
- The Secretary will also be required to report evaluation and findings to the President and Congress no later than September 30, 2011 and may use up to $1.1 million each year from FY2008 through FY2011 to carry out these activities; and
- The provision would appropriate $250 million for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; $300 million in FY2008; $350 million in FY2009; $400 million in FY2010; and $450 million in FY2011 to carry out the demonstration project; and
- Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2011.

Subchapter C – Miscellaneous

Medicaid Transformation Grants (Section 6081 of the Conference Agreement, no provision in the Senate Bill, and Section 3143 of the House Bill)**.**

Current Law

Section 1903(a) of the Social Security Act describes the level of federal reimbursement available to states for various Medicaid program functions. The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for Medicaid administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

Senate Bill

No provision.

House Bill

Under the House bill, in addition to the normal federal Medicaid reimbursement received by states under section 1903(a), the Secretary of HHS would provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Examples of innovative methods for which such funds may be used include: (1) methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs, (2) methods for improving rates of collection from estates of owed to Medicaid, (3) methods for reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, (4) implementation of a medication risk management program as part of a drug use review program, and (5) methods for reducing, in clinically appropriate ways, Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generics.

No payments would be made to a state unless the state applied to the Secretary of HHS for such payments in a form, manner, and time specified by the Secretary. Payments would be made under such terms and conditions consistent with the subsection as the Secretary prescribes. Payment to a state under the subsection would be conditioned on the state submitting to the Secretary an annual report on the programs supported by such payment. The reports would include information on: (1) the specific uses of such payment, (2) an assessment of the quality improvements and clinical outcomes under such programs, and (3) estimates of the cost savings resulting from such programs.

Total payments would equal and not exceed $50 million in each of FY2007 and FY2008. The Secretary would specify a method for allocating the funds among states. Such method would provide preference for states that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. The method would also allocate at least 25% of the funds among states whose populations as of July 1, 2004 were more than 105% of their populations as of April 1, 2000.

Conference Agreement

The conference agreement follows the House bill, but would increase total payments to equal and not exceed $75 million in each of FY2007 and FY2008. The agreement also adds, as an additional option for use of funds, methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital clinic systems. Conferees believe that it is important to develop new models to meet the needs of the uninsured. University based physicians are uniquely qualified to assume this task. Bringing the resources of academia and health care system together to serve the poor and medically needy will create new opportunities to develop strategies that can be used on a broader scale.

Improved Enforcement of Documentation Requirements (Section 6082 of the Conference Agreement, no provision in the Senate Bill, and Section 3145 of the House Bill)**.**

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien (e.g., a legal permanent resident, refugee, alien granted asylum or related relief) who meets all other Medicaid program eligibility criteria. Non-qualified aliens (e.g., those who are unauthorized or illegally present, non-immigrants admitted for a temporary purpose such as education or employment, short-term parolees) who would otherwise be eligible for Medicaid except for their immigration status may only receive Medicaid care and services that are necessary for the treatment of an emergency medical condition and are not related to an organ transplant procedure.

As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. If an individual declares that he or she *is* a citizen or national, the state is not required to obtain additional documentary evidence but may choose to do so. According to a 2005 report from the Department of Health and Human Services' Office of Inspector General, 46 states and the District of Columbia allow or sometimes allow self-declaration of United States citizenship, while four states require Medicaid applicants to submit documentary evidence to verify citizenship statements.

If an individual declares that he or she *is not* a citizen or national, the individual must declare that he or she is a qualified alien and must present: (1) alien registration documentation or other proof of immigration registration from the Department of Homeland Security's United States Citizenship and Immigration Services Bureau (DHS/USCIS, formerly the Immigration and Naturalization Service) or (2) other documents determined by the state to constitute reasonable evidence of satisfactory immigration status. If an individual presents DHS/USCIS

documentation, the state must verify the individual's immigration status with DHS/USCIS through the automated Systematic Alien Verification for Entitlements (SAVE) system, or by using an alternative verification system approved by the Secretary of Health and Human Services. States receive 100% federal reimbursement for the operation of such systems.

Senate Bill

No provision.

House Bill

Under the House bill, states would be prohibited from receiving federal reimbursement for medical assistance provided under Medicaid to an individual who has not provided satisfactory documentary evidence of citizenship or nationality.

Such evidence would include one of the following documents:

- a United States passport;
- Form N-550 or N-570 (Certificate of Naturalization);
- Form N-560 or N-561 (Certificate of United States Citizenship);
- such other document that the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

Satisfactory documentary evidence would also include a document from each of the following lists:

- a certificate of birth in the United States;
- Form FS-545 or Form DS-1350 (Certificate of Birth Abroad);
- Form I-97 (United States Citizen Identification Card);
- Form FS-240 (Report of Birth Abroad of a Citizen of the United States); or
- such other document as the Secretary may specify (excluding a document specified by the Secretary as described above) that provides proof of United States citizenship or nationality;

AND

- any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act; or
- any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

The documentary requirements would not apply to an alien who is: (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income benefits, or (3) eligible for Medicaid on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

The provision would apply to determinations of initial eligibility for Medicaid made on or after July 1, 2006, and to redeterminations made after such date in the case of individuals for whom the new documentary requirements were not previously met.

Conference Agreement

The conference agreement follows the House bill**,** but allows a state-issued driver's license or other identity document described in section 274(A)(b)(1)(D) of the Immigration and Nationality Act as satisfactory evidence, but only if the state issuing the license or such document requires proof of U.S. citizenship before issuance or obtains a Social Security number from the applicant and verifies before certification that such number is valid and assigned to an applicant who is a citizen.

Health Opportunity Accounts (Section 6083 of the Conference Agreement, no provision in the Senate Bill, and Section 3134 of the House Bill)**.**

Current Law

Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. To qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Each state designs and administers its own program under broad federal guidelines. Variation exists among states in eligibility, covered services, and the delivery of, and reimbursement for services. States that wish to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program may seek approval for Section 1115 demonstration waivers.

Medicaid's basic benefits rules require all states to provide certain "mandatory" services as listed in Medicaid statute. Federal matching payments are also available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each service to be provided under that plan within broad federal guidelines including: (1) *Amount, duration, and scope.* Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose, (2) *Comparability.* With certain exceptions, services available to any categorically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state. Similarly, services available to any medically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the state, (3) *Statewideness.* State plan services must be covered throughout an entire state, and (4) *Freedom of choice.* With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers or managed care entities participating in Medicaid.

States may generally impose nominal cost-sharing on beneficiaries, with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance, and services furnished to individuals receiving hospice care. States may require nominal copayments, coinsurance, or deductibles within federal limits from

other beneficiaries or for other services. Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.

For the most part, states establish their own rates to pay Medicaid providers for services. By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries.

Senate Bill

No provision.

House Bill

The House bill would require the Secretary of HHS to establish no more then 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. While demonstration programs described in the House bill have some of the elements of a Section 1115 demonstration waiver, "Health Opportunity Accounts," as defined by the provision, are not explicitly authorized under current law.

If successful during the initial 5-year test period, other demonstrations would be approved. HOAs would be used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs would be determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who would be precluded from participating. Once account holders were no longer eligible for Medicaid they could continue to make HOA withdrawals under state-specified conditions, though accounts could then also be used to pay for health insurance or, at state option, for job training or education. Among other things, state demonstration programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

Demonstration participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed $2,500 for each adult and $1,000 for each child.

Demonstration participants would be required to meet an annual deductible before they would be permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible would have to be at least 100%, but no more than 110%, of the annual state contributions to the HOA. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The House bill would require demonstration participants to be able to obtain services from Medicaid providers or managed care organizations at the same payment rates that would be applicable if the coverage deductible did not apply, or from any provider for payment rates not exceeding 125% of those rates.

Conference Agreement

The House bill is agreed to with the following modifications. The conference agreement requires the Secretary of HHS to establish no more then 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2007. If successful (based on cost-effectiveness, quality of care and other Secretary-specified criteria) during the initial 5-year test period, such demonstrations may be extended or made permanent, and other demonstrations may be approved. Not later than 3 months prior to the end of the initial 5-year test period, the conference agreement requires the Comptroller General of the Unites States to submit an evaluation of the demonstration programs to Congress.

HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs is determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, are among those who are precluded from participating. Once account holders are no longer eligible for Medicaid they may continue to make HOA withdrawals under state-specified conditions for a period of three years, though no additional account contributions will be made and the account balances will be reduced by 25%. For ineligible individuals who participated in the demonstration program for at least one year, accounts could then also be used to pay for health insurance or, at state option, for additional expenditures such as job training or education. The conference agreement adds a 1-year moratorium for reenrollment, whereby eligible individuals disenrolled from the state demonstration programs are not permitted to reenroll for a full year from such individual's disenrollment date. Among other things, state demonstration programs are required to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

The conference agreement requires demonstration participants have both an HOA and coverage for medical items and services that, after an annual deductible is met, are available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations as permitted under current law. Including federal shares, state contributions generally may not exceed $2,500 for each adult and $1,000 for each child.

The conference agreement requires demonstration participants to meet an annual deductible before they are permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible must be at least 100%, but no more than 110%, of the annual state contributions to the HOA without regard to state-specified limits on the HOA balance. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The conference agreement requires demonstration participants to be able to obtain services from Medicaid providers, or Medicaid managed care organizations at the same payment

rates that are applicable if the coverage deductible did not apply, or from any other provider or managed care organization at payment rates not exceeding 125% of such Medicaid provider payment rates. The conference agreement requires that the payment rates for Medicaid providers or managed care organizations be computed without regard to any cost sharing that are otherwise applicable under current law (as modified by the conference agreement).

State Option to Establish Non-emergency Medical Transportation Program (Section 6084 of the Conference Agreement, no provision in the Senate Bill, and Section 3125 of the House Bill)**.**

Current Law

Federal regulations require states to ensure necessary transportation for beneficiaries to and from providers. When states offer transportation as an optional benefit, federal reimbursement uses the federal assistance medical percentage (FMAP) rate which varies by state and ranges from 50% to 83%. FMAP reimbursement is only available if transportation is furnished by a provider to whom a direct payment can be made. Beneficiaries must have freedom of choice among transportation providers and such services must be equal in amount, duration and scope for all beneficiaries classified as categorically needy (CN). This comparability requirement also applies among medically needy (MN) groups. Other arrangements, such as payments to a broker who manages and pays transportation vendors, must be claimed as an administrative expense rather than as a benefit. Such costs are reimbursed by the federal government at 50%, and fewer federal requirements must be met.

Senate Bill

No provision.

House Bill

The House bill would allow states to establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care but have no other means of transportation. The state would not be required to provide comparable services for all Medicaid enrollees, nor freedom of choice among providers. The program would include wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and could be conducted under contract with a broker who: (1) is selected through a competitive bidding process that assesses the broker's experience, references, qualifications, resources and costs; (2) has oversight procedures to monitor beneficiary access and complaints and to ensure that transport personnel are licensed, qualified, competent and courteous; (3) is subject to regular auditing by the state to ensure quality of services and adequacy of beneficiary access to medical care; and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary. These provisions would be effective upon enactment.

The Office of the Inspector General (OIG) of DHHS would be required to submit a report to Congress examining the non-emergency medical transportation brokerage program implemented under this provision no later than January 1, 2007. This report must include findings regarding conflicts of interest and improper utilization of transportation services under this program, as well as recommendations for improvements.

Conference Agreement

The conference agreement includes the House bill, and specifies that non-emergency medical transportation brokerage programs do not have to be available statewide.

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program (Section 6085 of the Conference Agreement, no provision in the Senate Bill, no provision in the House Bill)**.**

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). States are currently required to provide TMA to families losing eligibility for Medicaid under two scenarios: one related to child or spousal support, and one related to work.

First, under 1931(c) of the Social Security Act, states must provide four months of TMA coverage to families losing Medicaid eligibility due to increased child or spousal support. This is a permanent provision of law with no sunset date.

Second, states are required to provide TMA to families losing Medicaid eligibility for work-related reasons. While Section 1902(e)(1) of the Social Security Act permanently requires states to provide four months of TMA to families losing Medicaid eligibility due to an increase in hours of work or income from employment, the Family Support Act (FSA) of 1988 expanded state TMA requirements under Section 1925 of the Social Security Act. As a result, states are currently required to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards have the effect of increasing the income level at which a family may qualify for Medicaid). FSA originally authorized Section 1925 to replace the four-month requirement in Section 1902(e)(1) through FY1998. However, the sunset date for Section 1925 has been extended a number of times, most recently through December 31, 2005.

Under Section 510 of the Social Security Act, federal law appropriated $50 million annually for each of the fiscal years 1998-2003 for matching grants to states to provide abstinence education and, at state option, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on groups that are most likely to bear children out-of-wedlock. Funds must be requested by states when they apply for Maternal and Child Health Services (MCH) Block Grant funds and must be used exclusively for the teaching of abstinence. States must match every $4 in federal funds with $3 in state funds.

A state's allotment of abstinence education block grant program funding is based on the proportion of low-income children in the state as compared to the national total. Funding for the abstinence education block grant has been extended through December 31, 2005 by temporary extension measures.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement extends TMA under Section 1925 of the Social Security Act through December 31, 2006. It also extends the $50 million annual appropriation for the abstinence education block grant program through fiscal year 2006 and provides an additional $12.5 million for the program for the first quarter of fiscal year 2007 (i.e., through December 31, 2006).

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Entities (Section 6086 of the Conference Agreement, no provision in the Senate Bill, and Section 3147 of the House Bill)**.**

Current Law

Medicaid law provides certain protections for beneficiaries enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.

Senate Bill

No provision.

House Bill

A Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCO must accept as payment in full the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) minus any payments for indirect costs of medical education and direct costs of graduate medical education. The effective date of this provision would be January 1, 2007.

Conference Agreement

The conference agreement includes the House bill, but clarifies that the fee-for-service rate is the maximum payment rate. Also, in a state where rates paid to hospitals under the state plan are negotiated by contract and not publicly released, the payment amount applicable under this provision must be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under the plan for tertiary hospitals.

Subtitle B- SCHIP

Additional allotments to eliminate fiscal year 2006 funding shortfalls (Section 6101 Subsection a of the Conference Agreement, Section 6051 Subsection a of the Senate Bill, and no provision in the House Bill)**.**

Current Law

In general, funds for the SCHIP program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount determined by a formula set in law. Federal funds not drawn from a state's allotment by the end of each fiscal year continue to be available to that state for two additional fiscal years. At the end of the three-year period, unspent funds from the original allotment are reallocated in ways that vary depending on the fiscal year. The original SCHIP law, (i.e., BBA97), specifies that only those states that spend all of their original allotment by the applicable three-year deadline would receive redistributed funds from the other states' unspent allotments, based on a process determined by the Secretary of Health and Human Services (HHS); and these redistributed funds would be available for one year. However, later laws (i.e., P.L. 106-554 and P.L. 108-74) overrode how the reallocation of unspent FY1998 to FY2001 original allotments would occur. The redistribution of unspent FY2002 SCHIP original allotments was determined by the Secretary of HHS in accordance with the default redistribution provision in BBA97.

Under current law, unspent original allotments from FY2003 forward are to be redistributed according to the original BBA97 methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.

Senate Bill

In general, the Senate bill would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two, and would specify rules for the reallocation of unspent FY2003, FY2004, and FY2005 SCHIP original allotments. The reallocated FY2003 and FY2004 funds would be available in FY2006; the reallocated FY2005 funds would be available in FY2007.

In FY2006, the Senate bill would require that unspent FY2003 original allotments remaining at the end of FY2005 (after a set-aside of 1.05% of the total unspent FY2003 funds for the territories) would be redistributed to states with an initial projected FY2006 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures in FY2006 would exceed the amounts available from the state's FY2005 and FY2006 original allotments. Each state with an initial projected shortfall would receive a portion of the available unspent FY2003 original allotments in proportion to its contribution to the total pool of such shortfalls. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2003 original allotments for the territories.

Also in FY2006, the Senate bill would require that the territories receive a set-aside of 1.05% of the total unspent FY2004 original allotments available at the end of FY2005. Described states would be permitted to extend the use of their unspent FY2004 original allotments in an amount equal to the shortfall still remaining after receiving redistributed FY2003 funds. Described states would be defined as states that: (1) spent all FY2003 original

allotments by the end of FY2005, (2) did not spend all of their FY2004 original allotment by the end of FY2005, and (3) reported an initial projected FY2006 shortfall. After the set-aside for the territories as well as the reduction of FY2004 extended funds for the described states, the remaining unspent FY2004 funds would be available to states with a net projected FY2006 shortfall, defined as each state's initial projected shortfall reduced by the redistributed FY2003 funds it received and by the extended FY2004 funds if it is a described state. Each state with a net projected shortfall would receive a redistribution of FY2004 funds to cover its net projected shortfall. Any remaining FY2004 unspent original allotments would then be extended proportionally to states that did not spend their FY2004 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2004 original allotments for the territories.

In FY2007, the Senate bill would require that the territories receive a set-aside of 1.05% of the total unspent FY2005 original allotments available at the end of FY2006. Described states would be permitted to extend the use of their unspent FY2005 original allotments in an amount equal to their initial projected FY2007 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures for FY2007 exceeds the amount available from the state's FY2006 and FY2007 original allotments. Described states would be defined as states that: (1) did not spend all of their FY2005 original allotment by the end of FY2006, and (2) reported an initial projected FY2007 shortfall. After the set-aside for the territories as well as the reduction of FY2005 extended funds for the described states, the remaining unspent FY2005 funds would be available to states with a net projected FY2007 shortfall, described as each state's initial projected shortfall reduced by the extended FY2005 funds for the described states. Each state with a net projected shortfall would receive a redistribution of FY2005 funds to cover its net projected shortfall or, if the remaining funds are inadequate to cover the FY2007 projected shortfalls, a portion of the available unspent FY2005 original allotments in proportion to the state's contribution to the total shortfall pool. If any FY2005 unspent original allotments remain, they would then be extended proportionally to states that did not spend their FY2005 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2005 original allotments for the territories.

To calculate the amounts available for redistribution and retention in each formula described above, the Secretary would use expenditures reported by states not later than November 30, 2005, for the FY2003 and FY2004 redistributions, and November 30, 2006, for the FY2005 redistribution. To calculate states with projected shortfalls in each formula described above, the Secretary would use projected expenditures reported by the states not later than September 30, 2005, for the FY2003 and FY2004 redistributions, and not later than September 30, 2006, for the FY2005 redistribution. This provision of the Senate bill would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

Out of money not otherwise available in the Treasury, the conference agreement authorizes and appropriates **$283 million** for the purpose of providing additional SCHIP allotments to shortfall states in FY2006. The conference agreement defines shortfall states as

those with an approved SCHIP plan for which (based on the most recent SCHIP data as of December 16, 2005) the Secretary estimates that such state's FY2006 projected expenditures exceed the sum of all funds available for expenditure by that state in FY2006 including: (1) the amount of such state's FY2004 and FY2005 original allotments that will not be expended in FY2005; (2) the amount, if any, that is redistributed to such state during FY2006; and (3) the amount of such state's FY2006 original allotment. From the additional SCHIP appropriation, each FY2006 shortfall state would receive an allotment to cover its projected shortfall or, if the appropriated funds are inadequate to cover the FY2006 projected shortfalls, the Secretary shall distribute the available funds on a pro rata basis based on each such state's estimated shortfall. Such additional SCHIP allotments are available for one year only. On October 1, 2006, any remaining unspent additional allotments will not be subject to redistribution, but will instead revert to the Treasury.

The conference agreement limits the types of payments that may be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the additional FY2006 appropriation available to shortfall states to include child health assistance payments made on behalf of targeted low-income children. The amendments made by this section of the conference agreement apply to items and services furnished on or after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued.

Prohibition against covering nonpregnant childless adults with SCHIP funds (Section 6102 of the Conference Agreement, and Section 6053 of the Senate Bill)**.**

Current Law

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter regarding treatment of adults. While this Administration was supportive of using the 1115 authority to expand SCHIP to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women, it opposed coverage of childless adults. Under the Bush Administration, the Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using the 1115 waiver authority. The initiative was created to encourage states to increase the number of individuals with health insurance coverage (including childless adults) within current program resources.

Senate Bill

The Senate bill would limit the Secretary of Health and Human Services's Section 1115 waiver authority by prohibiting the approval of new waiver, experimental, pilot, or demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children (as defined under Section 1931 of Medicaid statue), and to pregnant adults. Finally, the provision would allow for the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to

such projects) affecting federal SCHIP funds that had been approved under the Section 1115 waiver authority before the date of enactment of this Act. This provision would be effective upon the enactment of this Act.

House Bill

No provision.

Conference Agreement

The Senate bill is agreed to.

Continued authority for qualifying states to use certain funds for Medicaid expenditures. (Section 6103 of the Conference Agreement, Section 6054 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Current law permits qualifying states (i.e., states that on or after April 15, 1997, had an income eligibility standard for children, other than infants, of at least 184% of the FPL.– Other qualifications also apply to states with statewide waivers under Section 1115 of the Social Security Act.) to receive the SCHIP enhanced federal matching rate for the coverage of certain children enrolled in regular Medicaid. Specifically, for services delivered to Medicaid beneficiaries under the age of 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the FPL, federal SCHIP funds can be used to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid federal matching rate. The maximum amount that qualifying states may claim under this allowance is the lesser of the following two amounts: (1) 20% of the state's available FY1998 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending. No 20% spending will be permitted in FY2006 or any fiscal year thereafter.

House Bill

No provision.

Senate Bill

The Senate bill would continue the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the bill would allow qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for such Medicaid services made on or after October 1, 2005 under the 20% allowance. This provision of the Senate bill would be effective on or after October 1, 2005.

Conference Agreement

The Senate bill is agreed to.

Use of Redistributed Funds for Child Health Assistance for Targeted Low-income Children (No provision in the Conference Agreement, Section 6051_ Subsection b of the Senate Bill, and no provision in the House Bill)**.**

Current Law

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. The federal government contributes more toward the coverage of individuals in SCHIP than it does for those covered under Medicaid. All SCHIP assistance for targeted low-income children, including claims submitted to and approved by CMS for expenditures under the Section 1115 waiver authority, are matched at the enhanced federal medical assistance percentage (enhanced-FMAP).

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

Senate Bill

The Senate bill would limit the types of payments that could be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the FY2003, FY2004, and FY2005 redistributed funds available to shortfall states. Specifically, the Senate bill would require the federal government to make matching payments at the SCHIP enhanced matching rate for child health assistance payments made on behalf of targeted low-income children. However, expenditures drawn against the FY2003, FY2004, and FY2005 redistributed SCHIP funds would occur at the regular Medicaid FMAP rate for all other approved SCHIP expenditures, consisting of the following: (1) benefit expenditures for adults (other than pregnant women) approved under the Section 1115 waiver authority; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Authority to Use up to 10 Percent of Fiscal Year 2006 and 2007 Allotments for Outreach (No provision in the Conference Agreement, Section 6052 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

In general, Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate can be made for the following four specific health care activities: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for these four specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP insurance benefits and other specific health care activities combined. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a special rule for the redistribution of unspent FY1998 and FY1999 original allotments. Under BIPA, states that did not use all of their original allotments for the year were permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap, described above.

Senate Bill

The Senate bill would allow states to use up to 10% of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively. This allowance would be over and above spending for such activities under the general administrative cap described under current law. Outreach activities would include: (1) activities to promote the coordination of the administration of SCHIP with other public and private health insurance programs; and (2) strategies to market the program to the target population and to simplify and expedite the eligibility determination and enrollment process. This provision would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP (No provision in the Conference Agreement, Section 6055 of the Senate Bill, and no provision in the House Bill)**.**

Current Law

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the non-federal share, using state tax revenues, for example, but can also use local government funds to

comprise a portion of the non-federal share. Generally, the non-federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Senate Bill

The Senate bill would establish a new grant program under SCHIP to (1) finance outreach and enrollment efforts to increase participation of eligible children in both SCHIP and Medicaid, and (2) promote understanding of the importance of health insurance coverage for prenatal care and children. The Secretary would be permitted to reserve a portion of the grant funds for the purpose of awarding performance bonuses to eligible entities (defined below) that meet enrollment goals or other criteria established by the Secretary.

In awarding grants, the Secretary would be required to give priority to: (1) entities that propose to target geographic areas with high rates of eligible but not enrolled children, or racial and ethnic minorities and health disparity populations, and (2) entities targeting the same populations that are federal health safety net organizations (defined below) or faith-based organizations or consortia. Of the funds appropriated for this grant program (see below), 10% would be set aside for grants to certain Indian health care providers for outreach and enrollment of Indian children. These Indian health care providers would include the Indian Health Service (IHS) and Urban Indian Organization (UIO) providers that receive funds under Title V of the Indian Health Care Improvement Act.

The Senate bill would require entities seeking a grant to submit an application to the Secretary containing information on the quality and outcome performance measures to be used to evaluate the effectiveness of grant activities to ensure that these activities are meeting their goals. In addition, the application must provide assurances that the entity would: (1) conduct an assessment of the effectiveness using such performance measures, and (2) collect and report enrollment data and other information from these assessments to the Secretary in a form and manner as required by the Secretary.

The Senate bill would require the Secretary to disseminate to eligible entities and make publicly available the enrollment data and information collected and reported by grantees. The Secretary would also be required to submit an annual report to Congress on the funded outreach activities.

The Senate bill would require that federal funds awarded under this new grant be used to supplement, not supplant, non-federal funds that are otherwise available for these grant activities.

Specific definitions would be applicable to the new grant program. Five types of entities would be eligible to receive these grants, including: (1) state or local governments, (2) federal

health safety net organizations, (3) national, local or community-based public or nonprofit private organization, (4) faith-based organizations or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of Section 1955 of the Public Health Service Act (relating to grant awards to non-governmental entities), and (5) elementary or secondary schools. Federal health safety net organizations include a number of different types of entities, including for example: (1) Indian tribes, tribal organizations, UIOs and IHS providers, (2) federally qualified health centers, (3) hospitals that receive disproportionate share hospital (DSH) payments, (4) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects, certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (5) any other entity that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The Senate bill would appropriate $25 million for fiscal year 2007 for these grants. These grants would be in addition to existing SCHIP appropriations, and would not be subject to restrictions on expenditures for outreach activities under current law.

These provisions would be effective with the FY2007 appropriation for this new grant program.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Subtitle C – Katrina Relief

Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations (Section 6201 of the Conference Agreement, Sections 6032 and 6071 of the Senate Bill, and Sections 3100 and 3201 of the House Bill)**.**

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under SCHIP, subject to the availability of funds from a state's SCHIP allotment. In order for a state to receive federal Medicaid or SCHIP

reimbursement, it must have in effect a state plan approved by the Secretary of HHS that meets requirements set forth in federal statute and regulations.

Using an application template developed by the Centers for Medicare and Medicaid Service within HHS, a number of states (17 as of December 15, 2005) have been granted waivers under Section 1115 of the Social Security Act to provide Medicaid and SCHIP services to certain individuals affected by Hurricane Katrina (these waivers are referred to as being part of a multi-state demonstration project). For purposes of FMAP reimbursement, Section 1115 waivers are deemed to be part of a state's Medicaid or SCHIP state plan (i.e., its "regular" Medicaid or SCHIP program).

All of the waivers granted thus far under the Hurricane Katrina multi-state Section 1115 demonstration create a temporary eligibility period, not to exceed five months, during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP services in the host state (i.e., the state that has been granted a Section 1115 waiver) based on simplified eligibility criteria. In addition to creating temporary Medicaid or SCHIP eligibility for evacuees, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.

Disaster declarations were issued in the wake of Hurricane Katrina pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which authorizes the President to issue such declarations to speed a wide range of federal aid — including individual assistance (e.g., housing for individuals and families) and public assistance (e.g., repair of community infrastructure) — to states determined to be overwhelmed by hurricanes or other catastrophes. The Federal Emergency Management Agency (FEMA) makes the decision as to when a major disaster or emergency is "closed out" for administrative purposes.

Senate Bill

Under the Senate bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to individuals who resided during the week preceding Hurricane Katrina in one of the parishes of Louisiana or counties of Mississippi and Alabama specified in the bill. Costs directly attributable to related administrative activities would also be reimbursed at 100%.

A separate provision would allow the state of Louisiana, Mississippi, or Alabama to elect to not have the Medicaid subtitle of the bill apply with respect to the state during any period for which a major disaster declared in accordance with the Stafford Act with respect to a parish (in the case of Louisiana) or a county (in the case of Mississippi or Alabama) as a result of Hurricane Katrina is in effect.

House Bill

Under the House bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to: (1) any individual residing in a parish of Louisiana, a county of Mississippi, or a major disaster county of Alabama and (2) individuals who resided during the

week preceding Hurricane Katrina in a parish or county for which a major disaster has been declared as a result of the hurricane and for which the President has determined, as of September 14, 2005, warrants individual assistance under the Stafford Act. Costs directly attributable to related administrative activities would also be reimbursed at 100%.

A separate provision would allow the Medicaid subtitle of the bill to not apply during the 11-month period beginning September 1, 2005, to individuals entitled to Medicaid assistance by reason of their residence in a parish of Louisiana or a county of Mississippi or Alabama for which a major disaster has been declared as a result of Hurricane Katrina and for which the President has determined, before September 14, 2005, warrants individual and public assistance under the Stafford Act.

Conference Agreement

The conference agreement appropriates **$2 billion** (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have provided care to affected individuals or evacuees under a Section 1115 project) for the following purposes:

- the non-federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals who have been displaced to another state) under approved multi-state Section 1115 demonstration projects;
- reasonable administrative costs related to such projects;
- the non-federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP state plans; and
- other purposes, if approved by the Secretary, to restore access to health care in impacted communities.

The non-federal share paid to eligible states shall not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations may be incurred under approved multi-state Section 1115 projects for costs of: (1) health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006 and (2) uncompensated care or services and supplies beyond those included as Medicaid or SCHIP medical assistance incurred after January 31, 2006.

State High Risk Health Insurance Pool Funding (Section 6202 of the Conference Agreement, no provision in the Senate Bill, and Section 3202 of the House Bill)**.**

Current Law

A majority of states have established high-risk health insurance pool programs as one approach to reduce the number of uninsured persons. These programs target individuals who cannot obtain or afford health insurance in the private health insurance market, primarily because of pre-existing health conditions. Many states also use their high-risk pools to provide access to health insurance to individuals eligible under the guaranteed issue and portability provisions of

the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). In general, high-risk pools are operated through state-established nonprofit organizations that contract with private insurance companies to collect premiums, administer benefits, and pay claims. These programs tend to be small and enroll a small percentage of the uninsured. As of December 2004, 33 states operate high risk health insurance pool programs. Authorizing legislation for federal funding of these pools expired September 30, 2005.

Senate Bill

No provision.

House Bill

The House bill would amend the Public Health Service Act to reauthorize federal funding for state high risk health insurance pools. For FY2006, it would provide $90 million in appropriations for grants to states to be used to cover up to 50% of operating expenses of existing state high risk pools.

Conference Agreement

The conference agreement would appropriate, for FY2006, $75 million for the losses incurred by a State in connection with the operation of their qualified high risk pool. There is also $15 million in FY2006 appropriated to fund seed grants to States to create, and initially fund, a high risk pool. This funding will also apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005.

Recomputation of HPSA, MUA, and MUP Designations Within Hurricane Katrina Affected Areas (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3203 of the House Bill)**.**

Current Law

The Public Health Service Act provides for the designation of areas underserved by healthcare personnel, providing federal loans, scholarships and grants to improve the distribution of healthcare workers. The program is authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to review all such shortage designations in Hurricane Katrina declared disaster areas (pursuant to the Stafford Act), considering potential new shortages of health care workers.

Conference Agreement

No provision.

Waiver of Certain Requirements Applicable to the Provision of Health Care in Areas Impacted by Hurricane Katrina (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3204 of the House Bill)**.**

Current Law

The Public Health Service Act establishes requirements for federally qualified health centers and personnel in the National Health Service Corps. Programs are authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to relax certain requirements for the conduct of federally qualified health centers, and National Health Service Corps personnel staffing them, in areas directly affected by Hurricane Katrina, or indirectly affected by hosting large numbers of evacuees.

Conference Agreement

No provision.